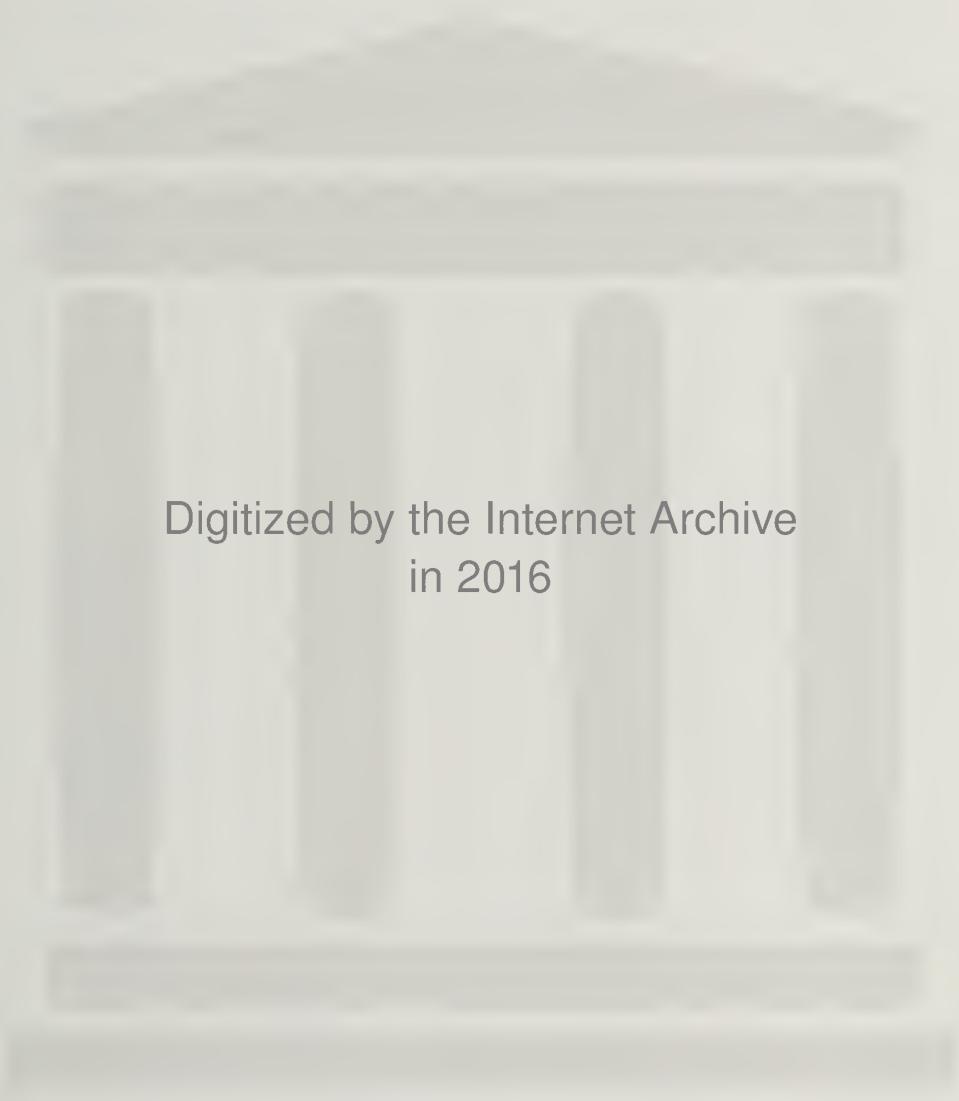
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THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

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*Source: Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.: Diabetes *8*:289, 1959.

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Order of Frequency of Presenting Symptoms in 110 Patients

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Polydipsia	89	81.0
Weight loss	47	42.7
Polyphagia	28	25.4
Anorexia	16	14.5
Lethargy	14	12.7
Enuresis	7	6.4
Vomiting	5	4.5
Irritability	3	2.7
"Craving for sweets"	3	2.7
"Sticky diaper"	3	2.7
"Strong odor to urine"	2	1.8
Glycosuria	2	1.8
Hypoglycemia	2	1.8
Personality change	1	0.9
Boils	1	0.9
Headache	1	0.9
Abdominal cramps	1	0.9

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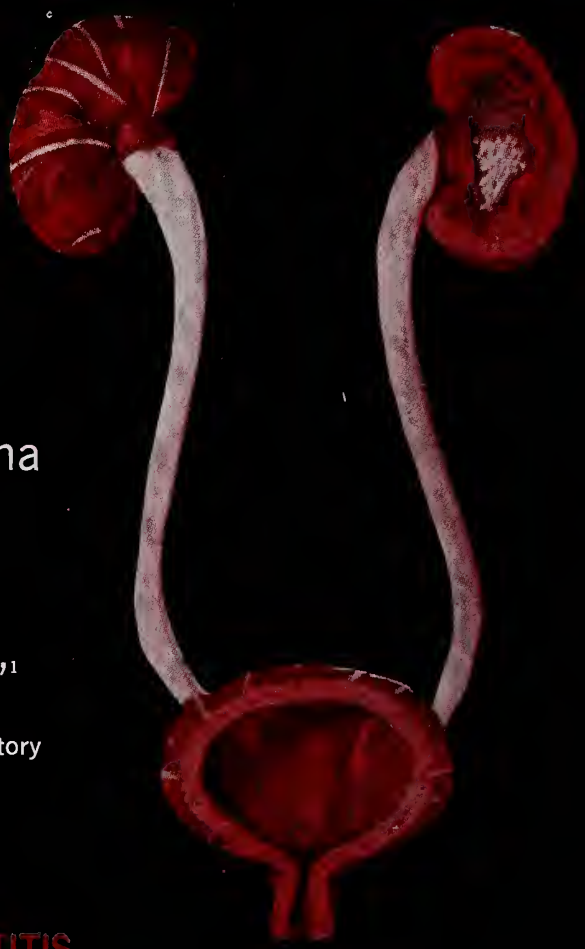
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*Thompson, R. E., and Hecht, R. A.: Am. J. Clin. Nutrition 7:311-317 (May-June) 1959.

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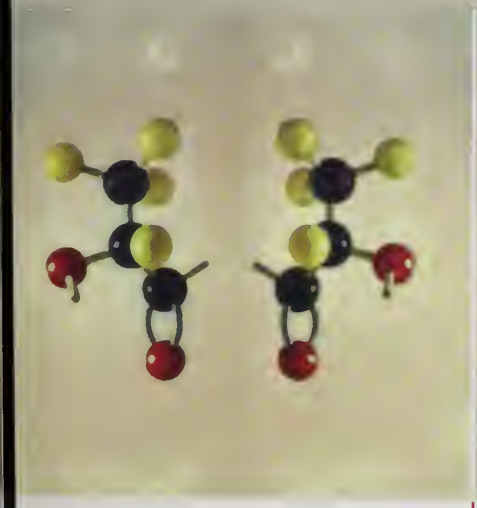
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MANY STAPH STRAIN MORE SENSITIVE TO SYNCILLIN

BRISTOL

ORIGIN OF A NEW SYNTHETIC PENICILLIN

In March, 1957, Dr. John C. Sheehan of the Massachusetts Institute of Technology announced the total synthesis of penicillin from common raw materials, thus solving a problem which had baffled research workers for more than 15 years. Although total synthesis was not commercially practicable, this work, sponsored by Bristol Laboratories, made possible the subsequent synthesis of new penicillins not occurring in nature. Later scientists at Beecham Laboratories in England discovered that a key intermediate (6-aminopenicillanic acid) could be produced by a fermentation process. With these achievements, large scale production of synthetic penicillins became feasible.

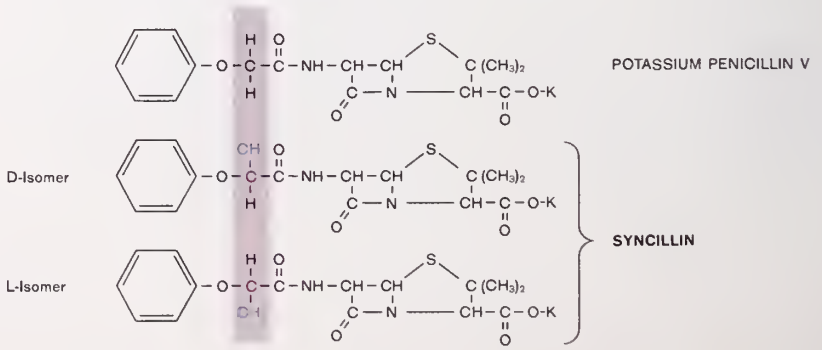
Organic chemists at Bristol then embarked upon an intensive program to develop better penicillins. Over five hundred were synthesized and underwent preliminary screening. Forty-six showed sufficient promise to warrant further investigation. Extensive microbiological, pharmacological, and clinical screening indicated that one compound, SYNCILLIN, had advantages of major importance over other penicillins.

SYNCILLIN is the N-acylation product of 6-aminopenicillanic acid and α-phenoxypropionic acid (the phenylether of lactic acid). It is freely soluble in water and remarkably resistant to decomposition by acid. The acid stability of SYNCILLIN is equivalent to that of penicillin V at pH 2 and pH 3 at 37° C.[1]

SIGNIFICANCE OF MOLECULAR ASYMMETRY AND ISOMERIC COMPLEMENTARITY

SYNCILLIN has a molecular configuration similar to penicillin V, but contains an additional CH_3 group so positioned as to render the adjacent carbon atom asymmetric. (In the formulae below, the added CH_3 group is shown in blue and the asymmetric carbon atom in red.) As a result, SYNCILLIN occurs as a mixture of two isomers.

Each isomer has been synthesized in essentially pure form and found to possess distinctive chemical and biological properties. The L-isomer is 2 to 17 times more active than the D-isomer against many of the organisms tested. As produced, SYNCILLIN is a mixture of the L-isomer and the D-isomer. As will be shown later, the antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than either isomer alone against many organisms. This phenomenon is referred to here as *isomeric complementarity.*



ISOMERIC COMPLEMENTARITY DEMONSTRATED IN VITRO

The *in vitro* minimum inhibitory concentration (MIC) of SYNCILLIN and of each of its two component isomers was determined for a variety of common pathogens and laboratory test organisms. As may be seen from Table 1, all three are highly effective against penicillin-susceptible staphylococci and against pneumococci, streptococci, gonococci, and corynebacteria; all are ineffective against Salmonella, *E. coli,* and other gram-negative coliform bacilli.

SYNCILLIN was more active against many of the test strains including some streptococci and staphylococci than either of its components. This demonstrates *in vitro* the phenomenon of isomeric complementarity.

TABLE 1

Minimum Concentrations of SYNCILLIN and Components Required to Inhibit a Wide Range of Bacteria

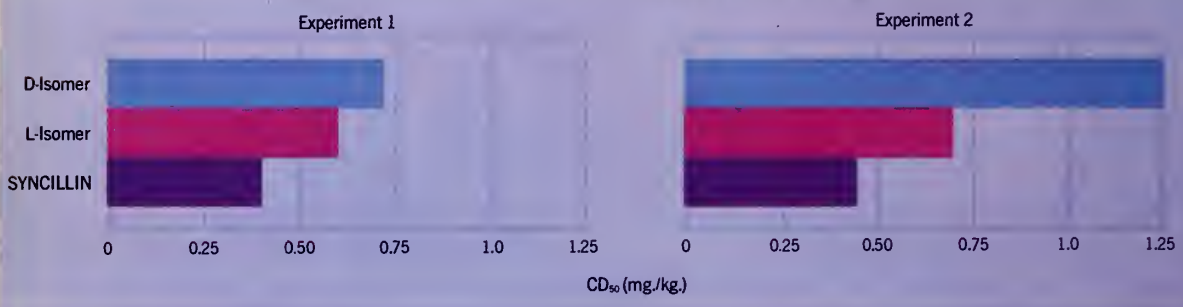
	Minimum Inhibitory Concentration (MIC) in Micrograms per Milliliter		
	L-Isomer	D-Isomer	SYNCILLIN
Bacillus anthracis	0.06	0.25	0.03
Bacillus cereus	12.5	100	25
Bacillus circulans ATCC 9961	6.25	6.25	6.25
Corynebacterium xerosis	0.06	0.125	0.03
*Diplococcus pneumoniae	0.06	0.06	0.06
Escherichia coli ATCC 8739	>100	>100	>100
Gaffkya tetragena	0.015	0.03	0.015
Micrococcus flavus	0.015	0.125	0.015
Salmonella paratyphi A	25	50	25
Salmonella typhosa	>100	>100	>100
Sarcina lutea ATCC 10054	0.007	0.12	0.007
Shigella sonnei	100	100	100
Staphylococcus aureus 209P	0.06	0.125	0.03
Staphylococcus aureus var. Smith	0.03	0.125	0.03
Streptococcus agalactiae ATCC 1077	0.03	0.06	0.03
Streptococcus dysgalactiae ATCC 9926	0.03	0.06	0.03
Streptococcus faecalis PCI 1305	6.25	25	6.25
*Streptococcus pyogenes 203	0.06	0.06	0.06
*Streptococcus pyogenes Digonnet	0.03	0.15	0.06
Streptococcus pyogenes 2320	0.06	0.06	0.03
Streptococcus pyogenes 23586	0.06	0.06	0.06
Vibrio comma	50	25	25

Serial dilution technique in heart infusion broth *10% serum added

ISOMERIC COMPLEMENTARITY CONFIRMED IN VIVO

To determine the median curative dose (CD_{50}) mice were infected with 100 times the lethal dose of *Staphylococcus aureus*. Each penicillin being tested was administered intramuscularly at the same time, and the dose required to cure half the animals determined. The greater effect of the mixture of the two isomers (SYNCILLIN) is shown in two independent experiments. (See Figure 1.) Note that isomeric complementarity is thus confirmed *in vivo*.

FIGURE 1 — Median Curative Dose (CD_{50}) for *Staphylococcus aureus* (var. Smith) Infections

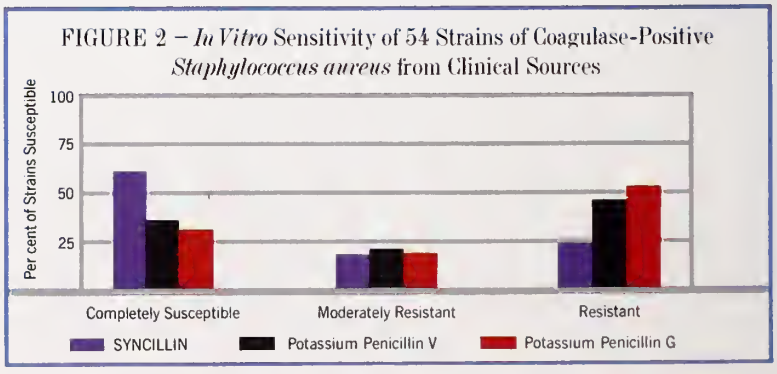


MANY STRAINS OF STAPHYLOCOCCI MORE SENSITIVE TO SYNCILLIN

SYNCILLIN has been tested against a large number of strains of *Staphylococcus aureus* isolated from clinical sources. Many organisms resistant to potassium penicillin G and potassium penicillin V proved sensitive to SYNCILLIN.

Wright[2] performed sensitivity studies on 54 strains, the majority of which were resistant or moderately resistant to penicillin V and penicillin G. Thirty-two (60%) of the strains were sensitive to SYNCILLIN, approximately twice as many as with the other penicillins. (See Figure 2.) In two-thirds of the isolates, SYNCILLIN produced inhibition at concentrations lower than those required for either of the other antibiotics. One strain was more sensitive to penicillin G.

FIGURE 2 – *In Vitro* Sensitivity of 54 Strains of Coagulase-Positive *Staphylococcus aureus* from Clinical Sources

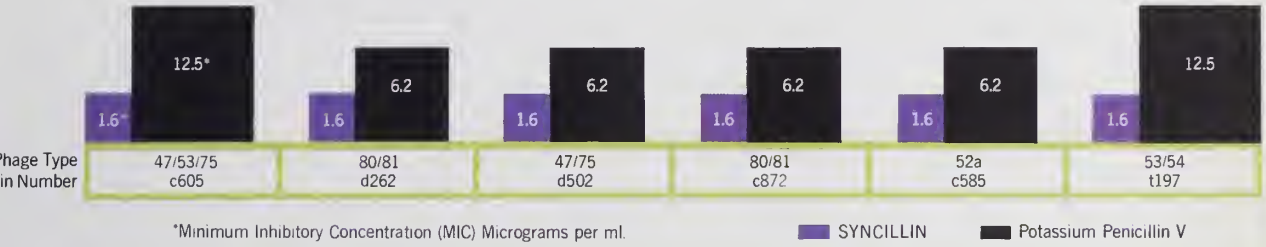


Adapted from Wright[2]

Of equal interest are the findings of White.[3] Six penicillin-resistant strains of staphylococci were isolated from hospital infections. None was sensitive to potassium penicillin V. All were sensitive to SYNCILLIN. (See Figure 3.)

FIGURE 3

Minimum Concentrations of SYNCILLIN Required to Inhibit Hospital Strains of *Staphylococcus aureus* Resistant to Potassium Penicillin V

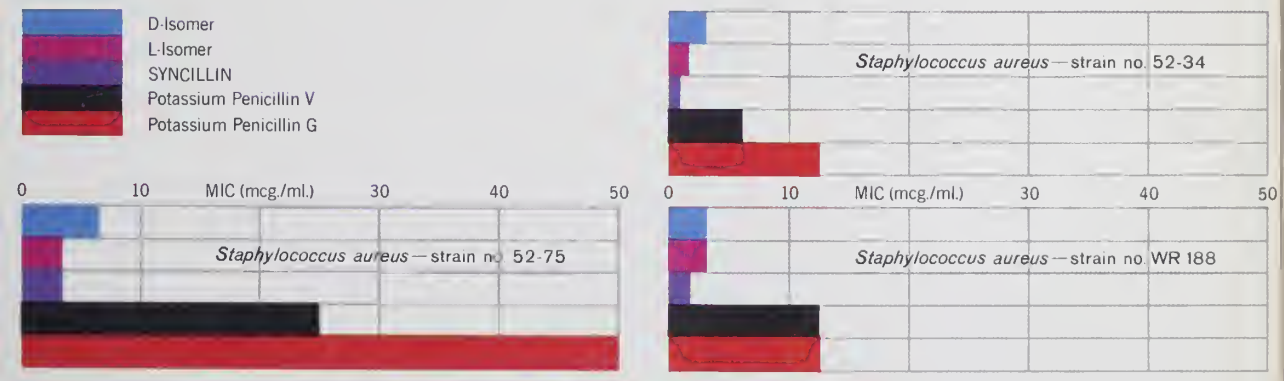


The efficacy of SYNCILLIN against the type 80/81 Staphylococcus (dangerous and widespread in hospitals) is worthy of special attention.

The complementary action of the component isomers is also seen with strains of staphylococci resistant to penicillins. Note that SYNCILLIN is more effective than either isomer against strains 52-34 and WR 188. (See Figure 4.) Against all three strains, SYNCILLIN is effective at concentrations below serum levels, while penicillins V and G are ineffective.

FIGURE 4

Minimum Inhibitory Concentrations (MIC) for Coagulase-Positive Penicillin-Resistant Strains of *Staphylococcus aureus*



Isomeric complementarity has thus been demonstrated for:

—— *certain penicillin-susceptible streptococci, staphylococci and corynebacteria* in vitro *(Table 1)*

—— *penicillin-susceptible staphylococci* in vivo *(Figure 1)*

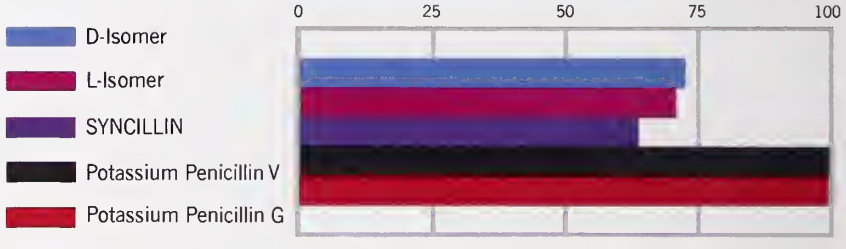
—— *penicillin-resistant staphylococci* in vitro *(Figure 4)*

ISOMERIC COMPLEMENTARITY SHOWN BY REDUCED RATE OF INACTIVATION BY PENICILLINASE

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms.[4] As shown in Figure 5, SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers – a further demonstration of isomeric complementarity. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V and penicillin G.

Resistance to SYNCILLIN develops in a slow, step-wise manner characteristic of other penicillins, in contrast to the usually rapid development of resistance to streptomycin.

FIGURE 5—Effect of Staphylococcal Penicillinase on Different Penicillins

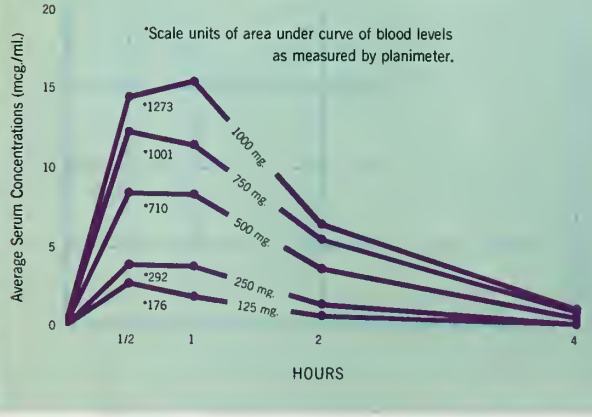


ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSAGE

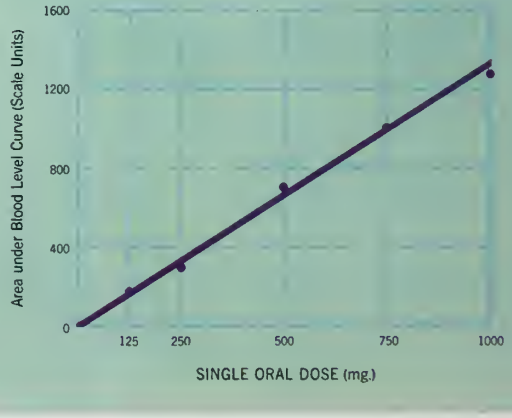
Cronk[5] studied blood levels after administering varying amounts of SYNCILLIN. (Figure 6.) Total antibiotic activity (obtained by measuring areas under curves with a planimeter) increases rapidly as the dose is doubled. These data show that increased dosage markedly increases serum concentration and thus may enhance the drug's effectiveness.

FIGURE 6

Serum Levels With Varying Dosage



Antibiotic Activity With Varying Dosage



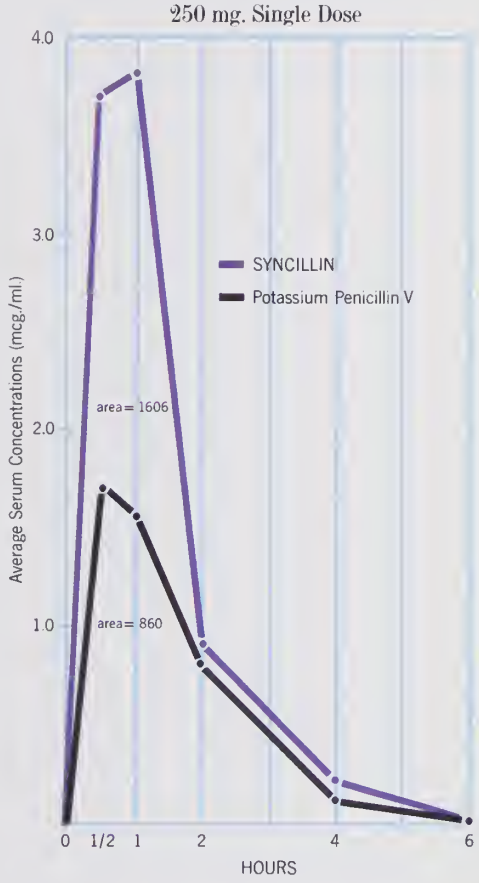
BLOOD LEVELS TWICE AS HIGH AS WITH POTASSIUM PENICILLIN V AFTER ORAL ADMINISTRATION

Wright[6] performed comparative crossover blood level studies on volunteer subjects receiving equivalent amounts of potassium penicillin V and SYNCILLIN. The peak concentrations attained during the first hour after administration were twice as high with SYNCILLIN.

The total antibiotic activity as measured by the area under the curves (see Figure 7) indicates an almost 2 to 1 superiority of SYNCILLIN (1606) over potassium penicillin V (860).

The higher blood levels may be of value with organisms of only moderate penicillin-sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition these higher levels may be necessary where there is infection in areas with a poor blood supply.[7] Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue.

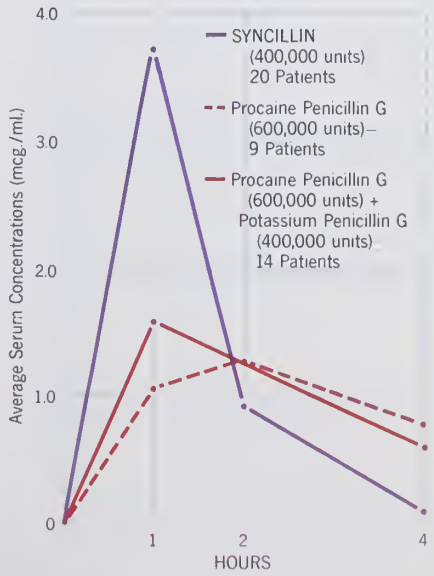
FIGURE 7
20 Subject Crossover
250 mg. Single Dose



BLOOD LEVELS MUCH HIGHER THAN WITH INTRAMUSCULAR PENICILLIN G

In addition, blood levels attained with oral SYNCILLIN[6] are much higher than those with intramuscular penicillin G.[8a, b] (See Figure 8.) Note that the level at one hour for SYNCILLIN (3.8 mcg./ml.) is more than twice as high as with procaine penicillin G, even when reinforced with potassium penicillin G (1.6 mcg./ml.). Since penicillins are *bactericidal,* these intermittent high serum levels can be clinically significant. Thus, SYNCILLIN offers the promise of superior efficacy via the safer oral route.

FIGURE 8—Serum Levels after Oral Administration of SYNCILLIN (250 mg.) and after Intramuscular Injection of Penicillin G



REDUCED HAZARD OF SERIOUS ALLERGENICITY BY SAFER ORAL ROUTE

SYNCILLIN has been administered in multiple doses to 437 patients and volunteers. One patient developed itching during therapy, possibly an allergic side effect. Another had a purpuric rash, but no relationship to SYNCILLIN was established. No reactions were observed in 9 patients with a known history of sensitivity to penicillin.

While the above data suggests the possibility of reduced allergenic hazard, no definite conclusions may be drawn at this time. *The usual precautions for oral penicillin therapy should be observed.* Patients with histories of asthma, hay fever, urticaria, or previous penicillin-sensitivity should especially be watched carefully. Since SYNCILLIN is administered orally, it may be expected to be safer than parenteral penicillin.

As Flippin[9] recently stated, "... it is well established that serious allergy to the drug [penicillin] is most likely to occur following parenteral administration, especially after repeated intramuscular injections; the oral route is least likely to initiate severe hypersensitivity reactions. This can be explained partly by the fact that when reactions develop following oral medication, they are usually slow enough to treat symptomatically; thus the progression of the reaction can usually be interrupted.... In view of the relatively high incidence of severe allergy to injectable penicillin, it would seem advisable to employ oral penicillin routinely, except in the control of infections involving the blood stream, endocardium, meninges, etc., in which cases the parenteral route remains the preferred treatment."

SYNCILLIN, like other penicillins, is essentially free of other toxicity. No hematopoietic, hepatic, or renal toxicity was observed in 210 volunteers receiving 1 gm. daily for 2 to 3 weeks.[10]

CLINICAL EFFICACY DEMONSTRATED IN PENICILLIN-SENSITIVE INFECTIONS

Clinical trials conducted by Blau and Kanof,[11] White,[12] Prigot,[13] Robinson,[14] Dube,[15] Ferguson,[16] Rutenburg,[17] Richardson,[18] Bunn,[19] Cronk,[5] Kligman,[10] and Yow [20] demonstrated the efficacy of SYNCILLIN in a variety of streptococcal, staphylococcal, pneumococcal, and gonococcal infections. Conditions treated included respiratory, skin, soft tissue, wound, and chronic urinary tract infections; acute gonorrhea; cellulitis; septicemia; otitis media; gingivitis; and Vincent's angina. In a few patients SYNCILLIN was used for rheumatic fever or gonorrheal prophylaxis.

One hundred seventy-two of one hundred ninety-six patients responded favorably to SYNCILLIN. The failures included 1 patient with pustular dermatoses, 10 elderly patients with chronic urinary tract infections, 1 patient with gonorrhea, 1 patient with a gram-negative infection, and 10 patients with staphylococcal infections. Lack of response of staphylococcal infections was attributed to the presence of resistant organisms or local suppurative foci requiring drainage.



Relatively few side effects were encountered. One patient experienced moderate itching of the skin which was controlled by an antihistamine. Another reported pruritus ani which did not interfere with therapy. Diarrhea occurred in 4 instances. There was one purpuric rash, but no relationship to SYNCILLIN could be established.

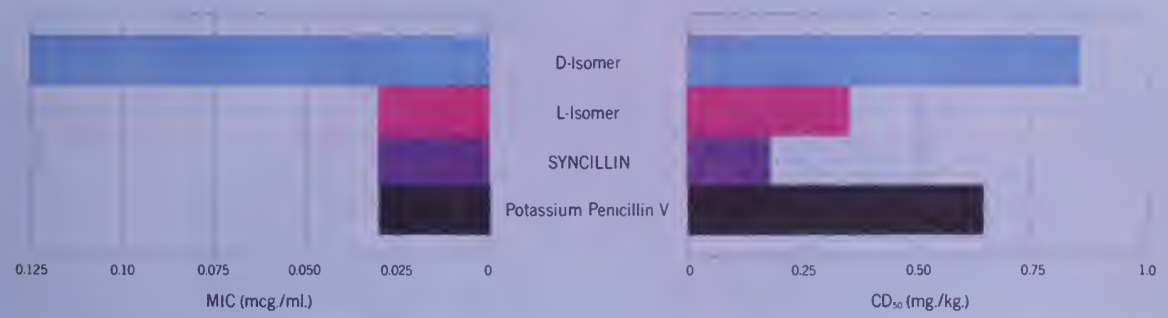
Clinical response usually begins within 24 hours in infections susceptible to SYNCILLIN. Recovery occurs in 4 to 7 days depending upon the severity of the infection. Gonorrheal infections respond very promptly to SYNCILLIN; 500 mg. b.i.d. for two days usually produce bacteriologic cures.

IMPROVED ANTIBIOTIC EFFECT FROM COMPLEMENTARY ACTION OF ISOMERS

SYNCILLIN is a mixture of isomers. The L-isomer is 2 to 17 times more active than the D-isomer against many of the organisms tested. Furthermore, the D- and L-isomers have other distinguishing chemical, pharmacological, and microbiological properties. Their *in vivo* and *in vitro* activities differ for many important pathogens. *Against many of the organisms tested, the combination of isomers* (SYNCILLIN) *is much more active than the stronger isomer alone.* This phenomenon of isomeric complementarity is not always demonstrable, for in a few instances SYNCILLIN is slightly less active.

Isomeric complementarity has previously been demonstrated *in vitro* (Figure 4) and *in vivo* (Figure 1). Figure 9 reveals a third form of superiority related to isomeric complementarity. Equal concentrations of SYNCILLIN and penicillin V were required to inhibit this growth of staphylococci *in vitro*. But, *in vivo*, a much smaller amount of SYNCILLIN *(one-third that of penicillin V)* was effective in an experimental infection with the same strain. These observations on complementary action indicated the advantage of producing the mixture of isomers as the medication to be made available for clinical therapy.

FIGURE 9 — Comparison of CD_{50} and MIC Values Against *Staphylococcus aureus* (var. Smith)



Isomeric complementarity has thus been demonstrated for:

—— *certain penicillin-susceptible streptococci, staphylococci and corynebacteria* in vitro *(Table 1)*

—— *penicillin-susceptible staphylococci* in vivo *(Figures 1 and 9)*

—— *penicillin-resistant staphylococci* in vitro *(Figure 4)*

—— *staphylococcal penicillinase antibiotic inactivation (Figure 5)*

Indications:

SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins.

SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage:

125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals.

Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions:

While present data suggest the possibility of reduced allergenic hazard, no definite conclusions may be drawn at this time. *Therefore the usual precautions with oral penicillin therapy must be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care.

Diarrhea has been reported occasionally following heavy dosage. If this occurs, the interval between dosages should be lengthened.

If superinfection occurs during therapy, appropriate measures should be taken.

Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply:

125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

References: 1. Lein, J.: Microbiology report to Bristol Laboratories Inc. 2. Wright, W. W.: Microbiology report to Bristol Laboratories Inc. 3. White, A. C.: Microbiology report to Bristol Laboratories Inc. 4. Dubos, R. J.: Bacterial and Mycotic Infections of Man, 3rd edition, Philadelphia, J. B. Lippincott Co., p. 690. 5. Cronk, G. A.: Clinical report to Bristol Laboratories Inc. 6. Wright, W. W.: Clinical report to Bristol Laboratories Inc. 7. Kass, E. H.: Am. J. Med. *18*:764 (May) 1955. 8a. White, A. C.; Couch, R. A.; Foster, F.; Calloway, J.; Hunter, W., and Knight, V.: in Welch, H. and Marti-Ibañez, F.: Antibiotics Annual — 1955-1956, Medical Encyclopedia, Inc., New York, 1956, p. 490. b. Data on file — at Bristol Laboratories. 9. Flippin, H. F.: Pennsylvania M. J. *62*:864 (June) 1959. 10. Kligman, A.: Clinical report to Bristol Laboratories Inc. 11. Blau, S., and Kanof, N.: Clinical report to Bristol Laboratories Inc. 12. White, A. C.: Clinical report to Bristol Laboratories Inc. 13. Prigot, A.: Clinical report to Bristol Laboratories Inc. 14. Robinson, C.: Clinical report to Bristol Laboratories Inc. 15. Dube, A. H.: Clinical report to Bristol Laboratories Inc. 16. Ferguson, B.: Clinical report to Bristol Laboratories Inc. 17. Rutenburg, A. M.: Clinical report to Bristol Laboratories Inc. 18. Richardson, J. H.: Clinical report to Bristol Laboratories Inc. 19. Bunn, P. A.: Clinical report to Bristol Laboratories Inc. 20. Yow, E. M.: Clinical report to Bristol Laboratories Inc.

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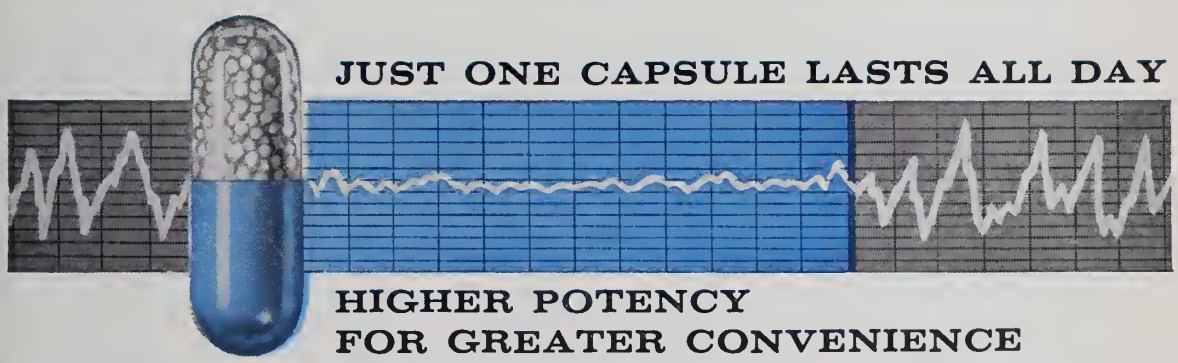


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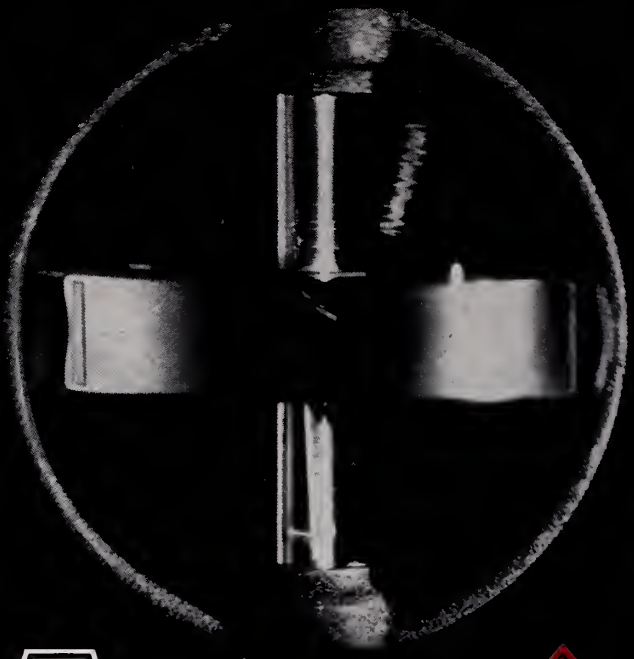
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References: 1. Feinberg, S.M., Feinberg, A.R., and Fisherman E.W.: *J.A.M.A.* 167:58 (May 3) 1958. 2. Epstein, J.I. and Sher wood, H.: *Connecticut Med.* 22:822 (Dec.) 1958. 3. Friedlaender, S and Friedlaender, A.S.: *Antibiotic Med. & Clin. Ther.* 5:31 (May) 1958. 4. Segal, M.S. and Duvenci, J.: *Bull. Tufts North Ea: M. Center* 4:71 (April-June) 1958. 5. Segal, M.S.: Report to th A.M.A. Council on Drugs, *J.A.M.A.* 169:1063 (March 7) 195 6. Sherwood, H. and Cooke, R.A.: *J. Allergy* 28:97 (Mar.) 195 7. Duke, C.J. and Oviedo, R.: *Antibiotic Med. & Clin. Ther.* 5:71 (Dec.) 1958. 8. McGavack, T.H.: *Clin. Med.* (June) 1958. 9. Fre berg, R.H.; Berutsen, C.A., and Hellman, L.: *Arthritis and Rhe matism* 1:215 (June) 1958. 10. Hartung, E.F.: *J.A.M.A.* 167:9 (June 21) 1958. 11. Hartung, E.F.: *J. Florida Acad. Gen. Prac* 8:18, 1958. 12. Zuckner, J.; Ramsey, R.H.; Caciolo, C., and Gan ner, G.E.: *Ann. Rheum. Dis.* 17:398 (Dec.) 1958. 13. Appel, B Tye, M.J., and Leibsohn, E.: *Antibiotic Med. & Clin. Ther.* 5:7 (Dec.) 1958. 14. Kalz, F.: *Canad. M.A.J.* 79:400 (Sept.) 195 15. Mullins, J.F., and Wilson, C.J.: *Texas State J. Med.* 54:6 (Sept.) 1958. 16. Shelley, W.B.; Harun, J.S., and Pillsbury, D.M *J.A.M.A.* 167:959 (June 21) 1958. 17. DuBois, E.F.: *J.A.M.* 167:1590 (July 26) 1958. 18. McGavack, T.H.; Kao, K.T.; Leak D.A.; Bauer, H.G., and Berger, H.E.: *Am. J. Med. Sc.* 236:7 (Dec.) 1958. 19. Council on Drugs: *J.A.M.A.* 169:257 (Jan. 1 1959. 20. Reiu, C.R.; Fleischnajer, R., and Rosenthal, A.R *J.A.M.A.* 165:1821 (Dec. 7) 1957.

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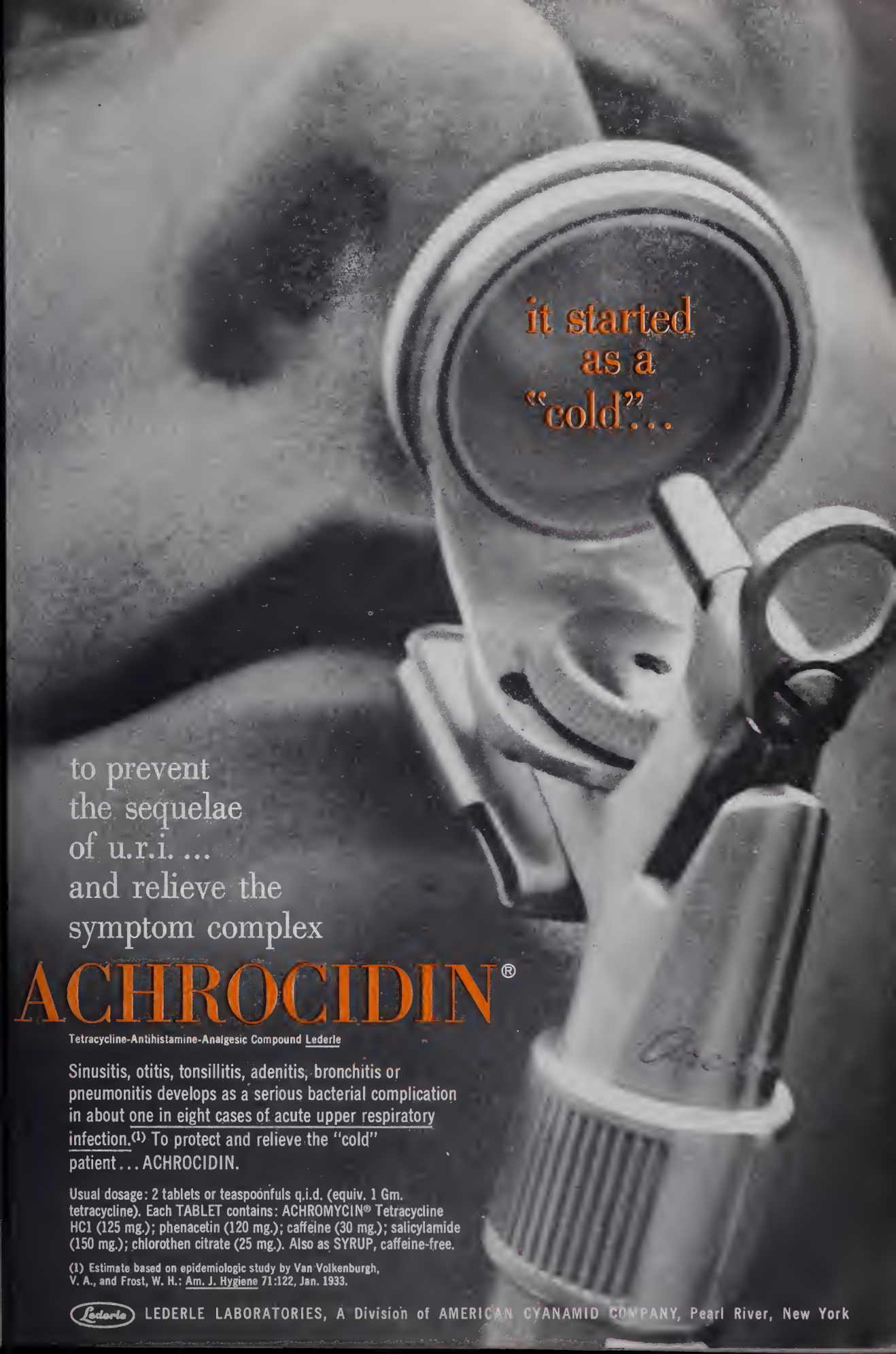
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(1) Estimate based on epidemiologic study by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122, Jan. 1933.

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*Activity level is a far more meaningful basis of comparison than quantitative blood levels, as Hirsch and Finland note. Action upon pathogens is the ultimate value.
(Hirsch, H. A. and Finland, M.: Antibacterial Activity of Serum of Normal Subjects after Oral Doses of Demethylchlortetracycline, Chlortetracycline and Oxytetracycline. *New England J. Med.* 260:1099 (May 28) 1959.)

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A masterpiece of



greater antibiotic activity

with far less antibiotic intake

unrelenting peak attack

—enhancing the unsurpassed features of tetracycline... for greater physician-patient benefits

DECLO

Demethylchlortetracycline Lederle

antibiotic design

REAFFIRMED
AT THE 1959
ANTIBIOTIC SYMPOSIUM
WASHINGTON,
D. C.

plus
"extra-
day"
activity

FOR PROTECTION
AGAINST
RELAPSE



MYCIN

A major contribution of Lederle research



in the distinctive dry-filled duotone capsule

DECLOMYCIN®

Demethylchlortetracycline Lederle

Available as: Capsules, 150 mg.
Pediatric Drops, 60 mg. per cc.
Oral Suspension, 75 mg. per 5 cc. tsp.

Reports presented at Seventh Annual Symposium on Antibiotics, Mayflower Hotel, Washington, D. C., November 4-6, 1959: 1. Boger, W. P. and Gavin, J. J.: Demethylchlortetracycline: Serum Concentration Studies and Cerebrospinal Fluid Diffusion. 2. Chávez Max, G.: Therapeutic Evaluation of Demethylchlortetracycline in Human Brucellosis. 3. Duke, C. J.; Katz, S., and Donohoe, R. F.: Demethylchlortetracycline in the Treatment of Pneumonia. 4. Finland, M.; Hirsch, H. A., and Kunin, C. M.: Observations on Demethylchlortetracycline. 5. Fujii, R.; Ichihashi, H.; Minamitani, M.; Konno, M., and Ishibashi, T.: Clinical Results with Demethylchlortetracycline in Pediatrics and Comparative Studies with Other Tetracyclines. 6. Garrod, L. P. and Waterworth, P. M.: The Relative Merits of the Four Tetracyclines. 7. Kanof, N. B. and Blau, S.: A Clinical Evaluation of Declomycin Demethylchlortetracycline in the Treatment of Pustular Dermatoses. 8. Kunin, C. M.; Dornbush, A. C., and Finland, M.: Distribution and Excretion of Four Tetracycline Analogues in Normal Men. 9. Marmell, M. and Prigot, A.: The Use of Demethylchlortetracycline in Gonorrhea, Lymphogranuloma Venereum, and Donovanosis. 10. Olarte, J.: The Sensitivity of Selected Strains of Shigella, Salmonella and Enteropathogenic *Escherichia coli* to Demethylchlortetracycline and Tetracycline. 11. Perry, D. M.; Hall, G. A., and Kirby, W. M. M.: Demethylchlortetracycline: A Clinical and Laboratory Appraisal. 12. Roberts, M. S.; Seneca, H., and Lattimer, J. K.: Demethylchlortetracycline in Genitourinary Infections. 13. Ross, S.; Puig, J. R.; and Zaremba, E. A.: Absorption of Demethylchlortetracycline in Infants and Children: Some Preliminary Observations. 14. Vineyard, J. P.; Hogan, J., and Sanford, J. P.: Clinical and Laboratory Evaluation of Demethylchlortetracycline.

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Pearl River, New York

Lederle

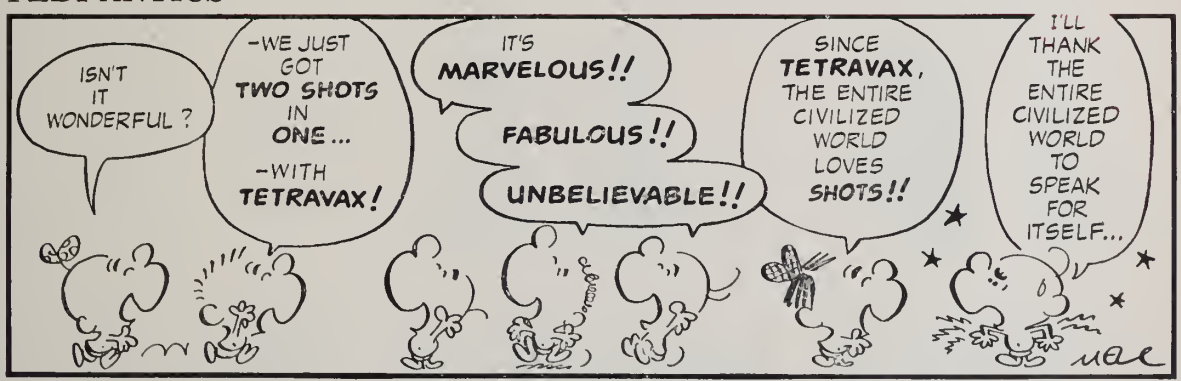
℞

Declomycin Caps
150 mg.
Disp # XVI
Sig 1 cap q.i.d.

FOR SIMULTANEOUS IMMUNIZATION AGAINST 4 DISEASES:

Poliomyelitis-Diphtheria-Pertussis-Tetanus

PEDI-ANTICS



TETRAVAX®

DIPHTHERIA AND TETANUS TOXOIDS WITH PERTUSSIS AND POLIOMYELITIS VACCINES

now you can immunize against more diseases...with fewer injections

Dose: 1 cc.
Supplied: 9 cc. vials in *clear plastic* cartons. Package circular and material in vial can be examined without damaging carton. Expiration date is on vial for checking even if carton is discarded.



For additional information, write Professional Services, Merck Sharp & Dohme, West Point, Pa.

TETRAVAX IS A TRADEMARK OF MERCK & CO., INC.

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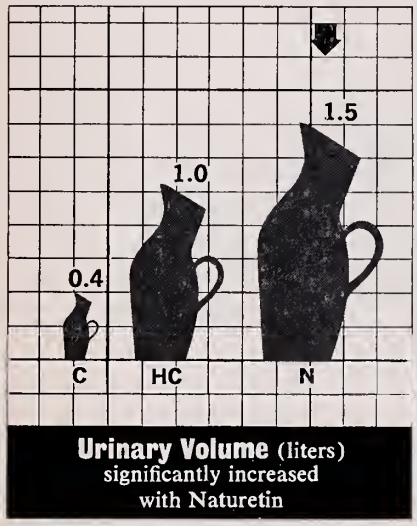
more closely approaches the ideal diuretic

Naturetin

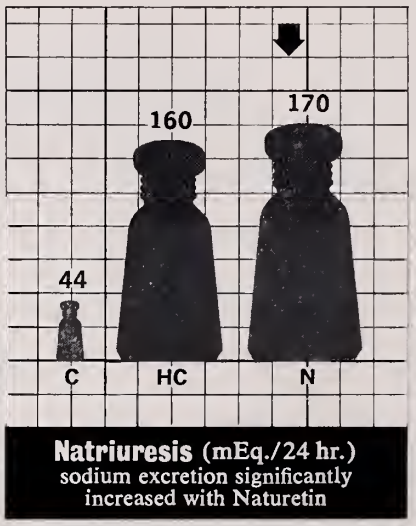
Squibb Benzydroflumethiazide

"When compared to other members of this heterocyclic grou of compounds, this drug [NATURETIN] shows a significantly i creased natriuresis and decreased loss of potassium and bica bonate. In this respect it more closely approaches a natural 'ideal diuretic.' It is effective upon continuous administration an causes no significant serum biochemical changes. It is effecti in a wide variety of edematous and hypertensive states an represents a significant advance in diuretic therapy." *Ford, R.V Pharmacological observations on a more potent benzothiadiazi diuretic; accepted for publication by the American Heart Journa*

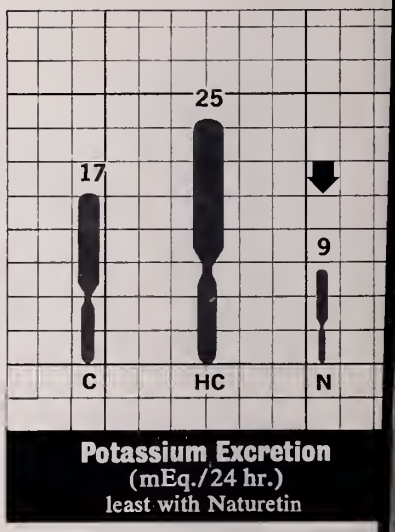
Comparison of electrolyte excretion pattern for the 24 hours following typical doses of chlorothiazide, hydrochlorothiazide, and Naturetin



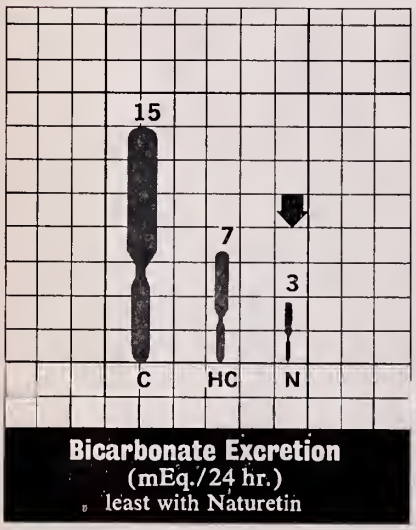
Urinary Volume (liters)
significantly increased
with Naturetin



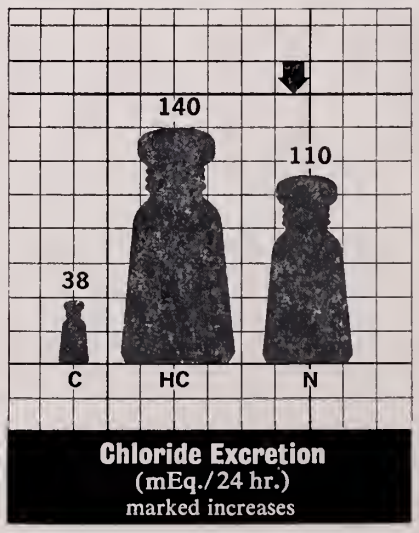
Natriuresis (mEq./24 hr.)
sodium excretion significantly
increased with Naturetin



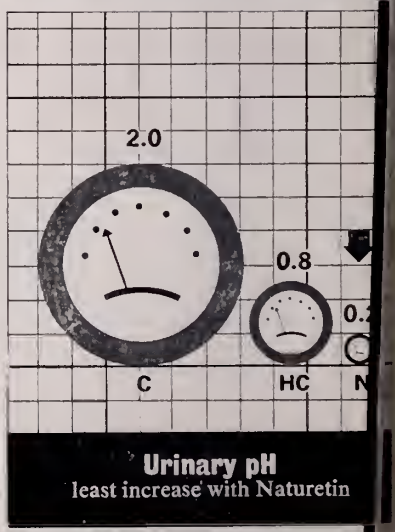
Potassium Excretion
(mEq./24 hr.)
least with Naturetin



Bicarbonate Excretion
(mEq./24 hr.)
least with Naturetin



Chloride Excretion
(mEq./24 hr.)
marked increases



Urinary pH
least increase with Naturetin

Typical Doses: Chlorothiazide—1,000 mg.; Hydrochlorothiazide—50 mg.; Naturetin (Benzydroflumethiazide)—5 m

1. Adapted from: Ford, R. V., Squibb Clin. Res. Notes 2:1 (Dec.)

A single 5 mg. tablet once a day provides all these advantages[2]

prolonged action — in excess of 18 hours

convenient once-a-day dosage

low daily dosage — more economical for the patient

no significant alteration in normal electrolyte excretion pattern

repetitively effective as a diuretic and antihypertensive

greater potency mg. for mg.—more than 100 times as potent as chlorothiazide

potency maintained with continued administration

low toxicity — few side effects — low salt diets not necessary

comparative studies with chlorothiazide, hydrochlorothiazide, and Naturetin disclose that smallest doses of Naturetin produce greater weight loss per day

in hypertension, Naturetin, alone or in combination with other anti-hypertensives, produces significant decreases in mean blood pressure and other favorable clinical effects

purpura and agranulocytosis not observed

allergic reactions rarely observed

[2]Reports (1959) to the Squibb Institute for Medical Research.

aturētin —*Indications:* in control of edema when diuresis is required, in congestive heart failure, the premenstrual syndrome, nephrosis and nephritis, cirrhosis with ascites, edema induced by drugs ertain steroids); in the management of hypertension, used alone, combined with Raudixin (Squibb uwolfia Serpentina Whole Root), or with other antihypertensive drugs, such as ganglionic blocking agents.

ntraindications: none, except in complete renal shutdown.

ecautions: when Naturetin is added to an antihypertensive regimen including hydralazine, ratrum, and/or ganglionic blocking agents, immediate reduction must be made in the dosage for all eparations; the dosage for ganglionic blocking agents must be decreased by 50% to avoid a precipitous p in blood pressure. This also applies if these hypotensive drugs are added to an established Naturetin imen . . . in hypochloremic alkalosis with or without hypokalemia . . . in cirrhotic patients or those on italis therapy when reductions in serum potassium are noted . . . in diabetic patients or those disposed to diabetes . . . when increased uric acid concentrations are noted . . . when signs— or abdominal cramps, pruritus, paresthesia, rash—suggestive of hypersensitivity, are noted.

aturētin —*Dosage: in edema,* average dose, 5 mg., once daily, preferably in the rning; to initiate therapy, up to 20 mg., once daily or in divided doses; for intenance, 2.5 to 5.0 mg., daily in a single dose. *In hypertension:* suggested tial dose, 5 to 20 mg. daily; for maintenance, 2.5 to 15 mg. daily, depending the individual response of the patient. When Naturetin is added to an anti-pertensive regimen with other agents, lower maintenance doses of each ug should be used.

turētin —*Supplied:* tablets of 2.5 mg. and 5 mg. (scored).

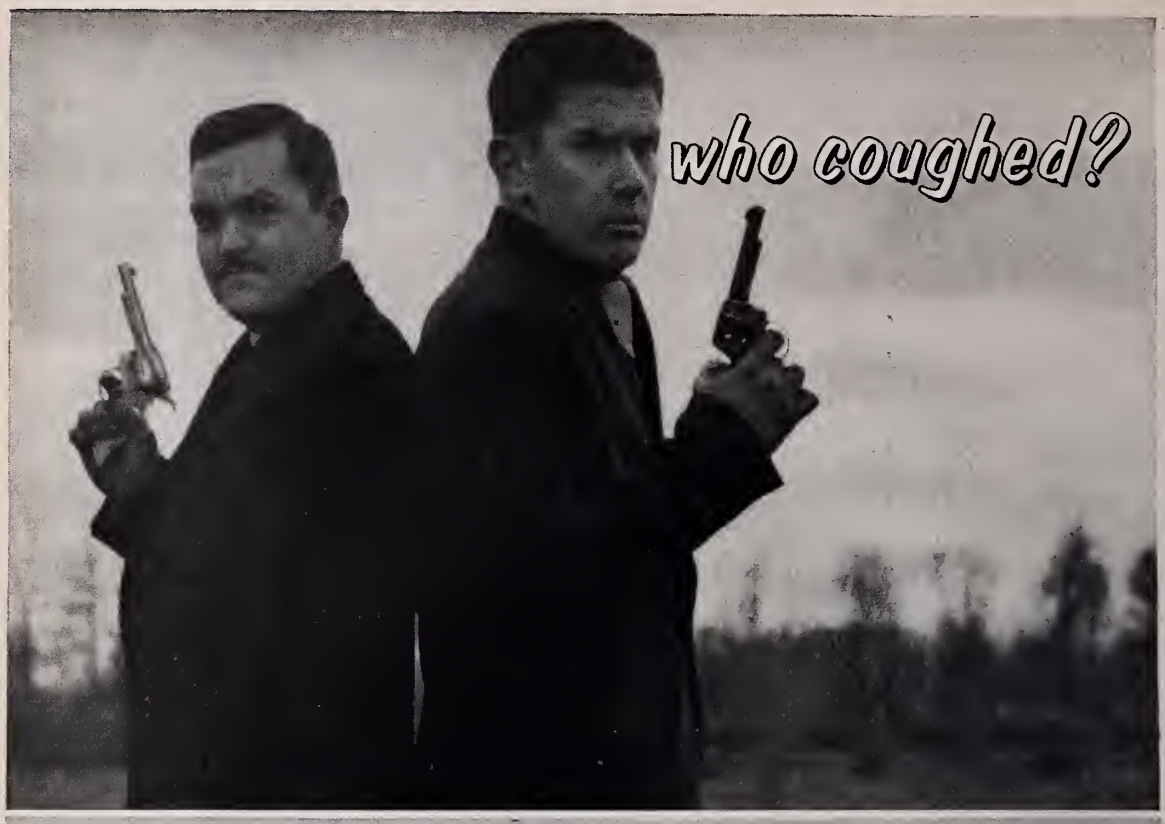
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Squibb Quality—
the Priceless
Ingredient

Rx
Naturetin 5mg.
Disp. #30
Sig: 1 each
morning

DIXIN,® AND 'NATURETIN' ARE SQUIBB TRADEMARKS.



WHENEVER COUGH THERAPY IS INDICATED

Hycomine®
SYRUP

THE *complete* Rx FOR COUGH CONTROL

cough sedative / antihistamine / expectorant

- relieves cough and associated symptoms in 15-20 minutes • effective for 6 hours or longer
- promotes expectoration • rarely constipates
- agreeably cherry-flavored

NOW MORE EFFECTIVE THAN EVER WITH THE NASAL DECONGESTANT PHENYLEPHRINE

Each teaspoonful (5 cc.) of HYCOMINE* contains:

Hycodan®		
Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.	6.5 mg.
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Supplied: As a pleasant-to-take syrup. May be habit-forming. Federal law permits oral prescription.

Endo®

Literature on request

ENDO LABORATORIES Richmond Hill 18, New York

* U.S. Pat. 2,630,400


anxiety pushing it up?
SERPASIL®
(reserpine CIBA)
makes it go down!
2/2767 MB
CIBA
SUMMIT, N. J.

Lifts depression..



An emotionally balanced patient

Thanks to your treatment and the help of Deprol, her depression is relieved and her anxiety and tension calmed. She eats well, sleeps well, and can return to her normal activities.

as it calms anxiety!

Deprol helps balance the mood by lifting depression as it calms related anxiety

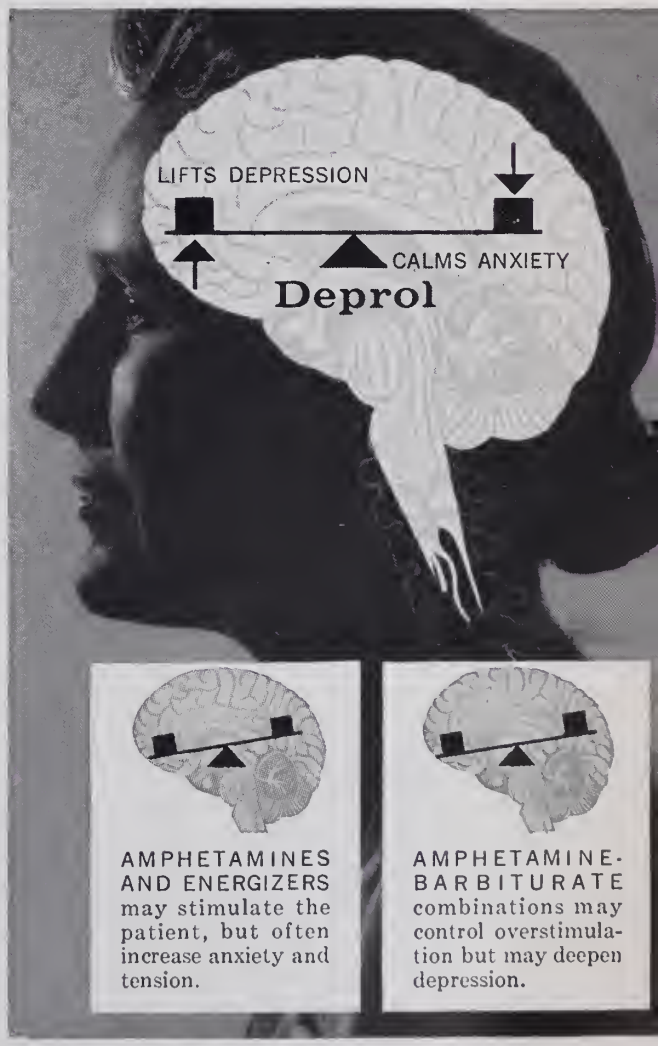
No "seesaw" effect of amphetamine-barbiturates and energizers

While amphetamines and energizers may stimulate the patient—*they often aggravate anxiety and tension.* And although amphetamine-barbiturate combinations may counteract excessive stimulation—*they often deepen depression.*

In contrast to such "seesaw" effects, Deprol lifts depression as it calms anxiety—both at the same time.

Safer choice of medication than untested drugs

Deprol does not produce hypotension, liver damage, psychotic reactions or changes in sexual function.



BIBLIOGRAPHY: 1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N.: Deprol as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy. In press, 1959. **3.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F.: Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **4.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B.: Treatment of depression—New technics and therapy. Am. Pract. & Digest Treat. In press, 1959. **5.** Pennington, V. M.: Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **6.** Rickels, K. and Ewing, J. H.: Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **7.** Ruchwarger, A.: Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **8.** Settel, E.: Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy. In press, 1959.

Deprol®

DOSAGE: Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d.

COMPOSITION: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

SUPPLIED: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

WALLACE LABORATORIES / *New Brunswick, N. J.*

CD-154

better orientated
more active
happier
geriatric
patients



MENIC™

C.N.S. stimulant

cerebral vasodilator



In the deteriorating senile patient with cerebral arteriosclerosis and mental confusion **MENIC** brightens the outlook for a more active, more normal, happier life . . . by acting to increase the oxygen and blood supply to the brain.

MENIC provides the effective analeptic, pentylenetetrazole[1], potentiated by the established cerebral vasodilator, nicotinic acid[2] . . . a safe, simple way to help retard and treat the senility syndrome.

Each scored tablet contains pentylenetetrazole 100 mg. (1½ gr.) nicotinic acid 50 mg. (5/6 gr.) in bottles of 100 and 500 tablets. Usual dose: 2 MENIC tablets t.i.d., p.c.

Literature and samples available upon request.

1. Kolomeyer, N.: J. Amer. Geriat. Soc. 6:415, 1958. 2. Levy, S.: J.A.M.A. 153:1260, 1953.

GERIATRIC PHARMACEUTICAL CORP. Bellerose L. I., N. Y.

Pioneers in Geriatric Research

GERIATRIC



NNOUNCING
CHERING'S
NEW
IYOGESIC[X]

RELA™

CARISOPRODOL

– EASES MUSCLE SPASM & PAIN IN SPRAINS, STRAINS, LOW BACK PAINS

X

[X]MYOGESIC
muscle relaxant – analgesic

Schering



for the tense and nervous patient

relief comes fast and comfortably

–does not produce autonomic side reactions
–does not impair mental efficiency, motor control, or normal behavior.

Usual Dosage: One or two 400 mg. tablets t.i.d.

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets or as MEPROTABS*–400 mg. *unmarked*, coated tablets.

Miltown®

meprobamate (Wallace)

WALLACE LABORATORIES / *New Brunswick, N. J.*

NOW

. . . a new way to relieve pain and stiffness in muscles and joints

indicated in:

MUSCLE STIFFNESS

LUMBOSACRAL STRAIN

SACROILIAC STRAIN

WHIPLASH INJURY

BURSITIS

SPRAINS

TENOSYNOVITIS

FIBROSITIS

FIBROMYOSITIS

LOW BACK PAIN

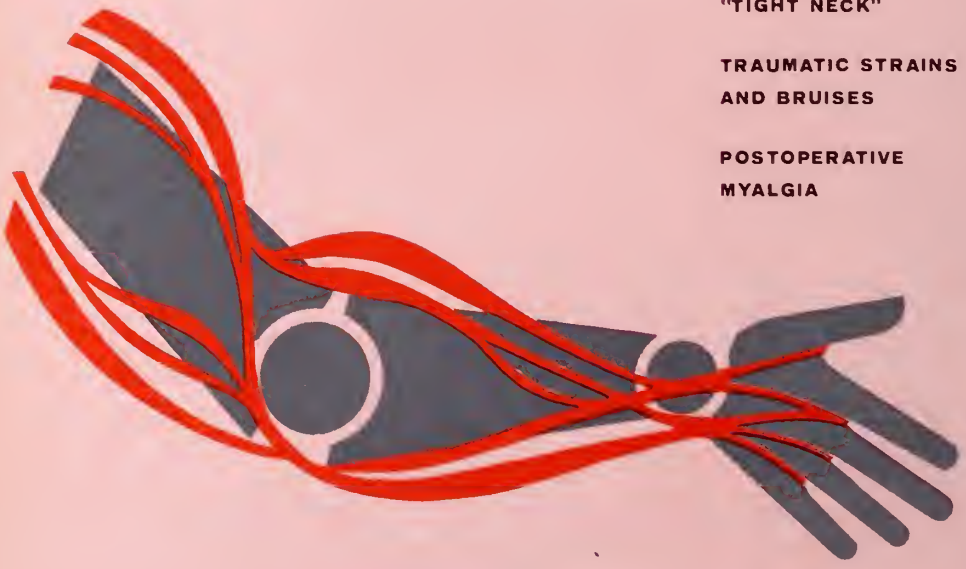
DISC SYNDROME

SPRAINED BACK

"TIGHT NECK"

TRAUMATIC STRAINS AND BRUISES

POSTOPERATIVE MYALGIA



■ Exhibits unusual analgesic properties, different from those of any other drug ■ Specific and superior in relief of SOMAtic pain ■ Modifies central perception of pain without abolishing natural defense reflexes ■ Relaxes abnormal tension of skeletal muscle

SOMA™

N-isopropyl-2-methyl-2-propyl-1, 3-propanediol dicarbamate

■ More specific than salicylates ■ Less drastic than steroids

■ More effective than muscle relaxants

SOMA has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. SOMA is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with SOMA than with previously used analgesic, sedative or relaxant drugs.
SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

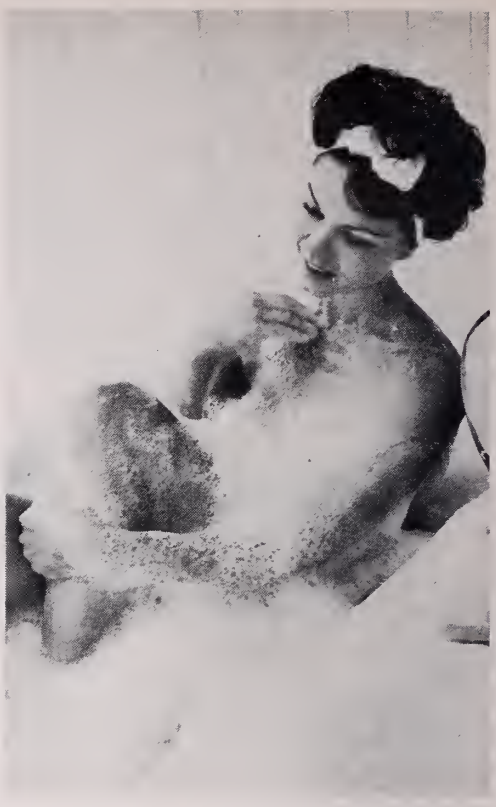
ACTS FAST. Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

NOTABLY SAFE. Toxicity of SOMA is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy, particularly on high dosage.

EASY TO USE. Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

SUPPLIED: Bottles of 50 white coated 350 mg. tablets.
Literature and samples on request.

WALLACE LABORATORIES, NEW BRUNSWICK, N. J.



in one preparation

the answer to your three most important requirements in a douche

For a dependable and effective means of treating non-specific leukorrhea

For adjunctive therapy in Trichomonas Vaginalis vaginitis and other specific infections

For personal cleanliness and the prevention of irritation and inflammation

TRICHOTINE is the first major douche to contain sodium lauryl sulfate, a detergent of the highest order of efficiency. TRICHOTINE penetrates and dissolves the viscid film covering the vaginal mucosa; gets down in the rugal folds, carrying medication directly to the mucosa and the invading organisms.

TRICHOTINE is a potent bactericide and fungicide, penetrating the walls

TRICHOTINE®





of many micro-organisms. "The douche solution is an effective agent against Trichomonas Vaginalis, Monilia Albicans, anaerobic organisms including a potent strain of streptococci that sometimes cause severe infections, and other non-specific vaginal micro-organisms."[1]

TRICHOTINE actually favors epithelial growth and healing, and the relief it affords from pruritis is quite striking.

For personal cleanliness, especially as a post-coital and post-menstrual douche, TRICHOTINE is designed to meet all the requirements of feminine hygiene. As an effective cleanser for office use, or for treatment, or for routine home douching, TRICHOTINE will prove satisfactory to you and its soothing, refreshing action will be reassuring to your patients.

1. Karnaky, K.J.: Med. Record and Annals, Houston 46:296 (Nov. 1952).

The Fesler Company, Inc., 375 Fairfield Avenue, Stamford, Conn.

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SYMPOSIUM REPORT:

ALTAFUR in surgical (soft tissue) infections

In a series of 159 patients with various types of surgical infections (cellulitis, abscess, wound infections), ALTAFUR was employed with eminently satisfactory results. The incidence and magnitude of surgery were considerably reduced in these cases, and when surgical intervention was necessary it could be delayed until the inflammatory process had receded or become localized.

Excellent therapeutic response was obtained in patients with infections due to coagulase positive Staphylococcus aureus, beta hemolytic Streptococcus, and Escherichia coli; these organisms were uniformly susceptible to ALTAFUR in vitro. An insensitive strain of Pseudomonas aeruginosa was isolated from the single patient who failed to respond. ALTAFUR was given orally to 150 patients, the majority receiving 100 mg. four times daily.* Duration of treatment ranged from 4 to 30 days, averaged 6 days. An experimental intravenous preparation of ALTAFUR was administered to 9 patients who could not take medication by mouth or whose condition warranted exceptionally high dosage. There was no clinical or laboratory evidence of toxicity in any case, and ALTAFUR was well tolerated by all but 1 of the 159 patients.

Prigot, A.; Felix, A. J., and Mullins, S.: Paper presented at the Symposium on Antibacterial Therapy. Michigan and Wayne County Academies of General Practice, Detroit, September 12, 1959 (published Nov. 1959)

*Experimental dosage (see dosage recommendations adjacent)

bright new star

in the antibacterial firmament

ALTAFUR™

brand of furaltadone

the first nitrofuran effective orally in systemic bacterial infections

- Antimicrobial range encompasses the majority of common infections seen in everyday office practice and in the hospital
- Decisive bactericidal action against staphylococci, streptococci, pneumococci, coliforms
- Sensitivity of staphylococci in vitro (including antibiotic-resistant strains) has approached 100%
- Development of significant bacterial resistance has not been encountered
- Low order of side effects
- Does not destroy normal intestinal flora nor encourage monilial overgrowth (little or no fecal excretion)

Tablets of 50 mg. (pediatric) and 250 mg. (adult)
Average adult dose: 250 mg. four times a day, with food or milk
Pediatric dosage: 22-25 mg./Kg. (10-11.5 mg./lb. body weight daily in 4 divided doses

CAUTION: The ingestion of alcohol in any form, medicinal or beverage, should be avoided during Altafur therapy.

NITROFURANS—a *unique* class of antimicrobials
EATON LABORATORIES, NORWICH, NEW YORK

Where a poly-unsaturated oil is called for in the diet **Wesson®** satisfies the most exacting requirements

(—and the most exacting appetites).



Compared to other readily available vegetable oils, Wesson is unsurpassed as a serum cholesterol depressant.

Each pint of Wesson contains 437-524 Int. Units of Vitamin E

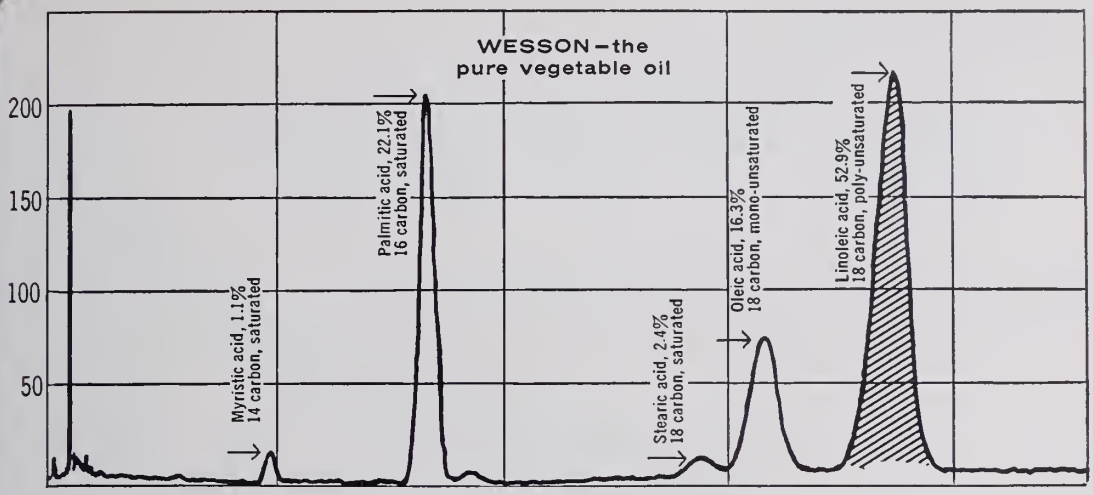
Faithful adherence to any diet is much more likely when foods taste good. The preference for Wesson—amply confirmed by its sales leadership for 59 years—has been reconfirmed in recent tests with brand identification removed. Housewives in a national probability sample indicated marked preference for Wesson, particularly by the criteria of odor, flavor (blandness) and lightness of color.

Wesson's Important Ingredients:

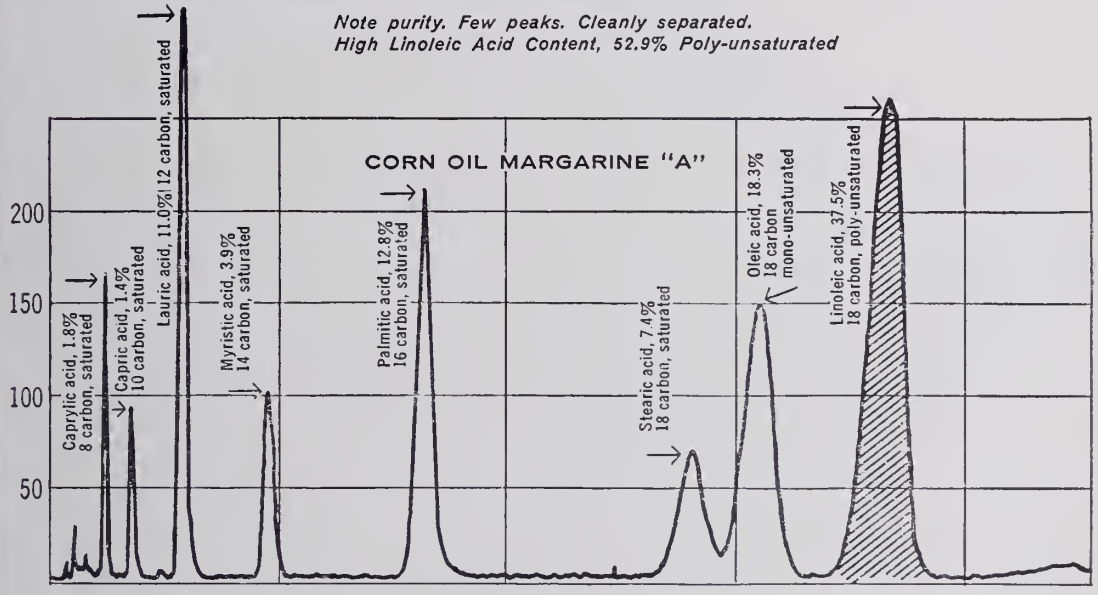
Linoleic acid glycerides	50% to 55
Phytosterol (predominantly beta sitosterol)	0.4% to 0.7
Total tocopherols	0.09% to 0.12

Never hydrogenated—completely salt free

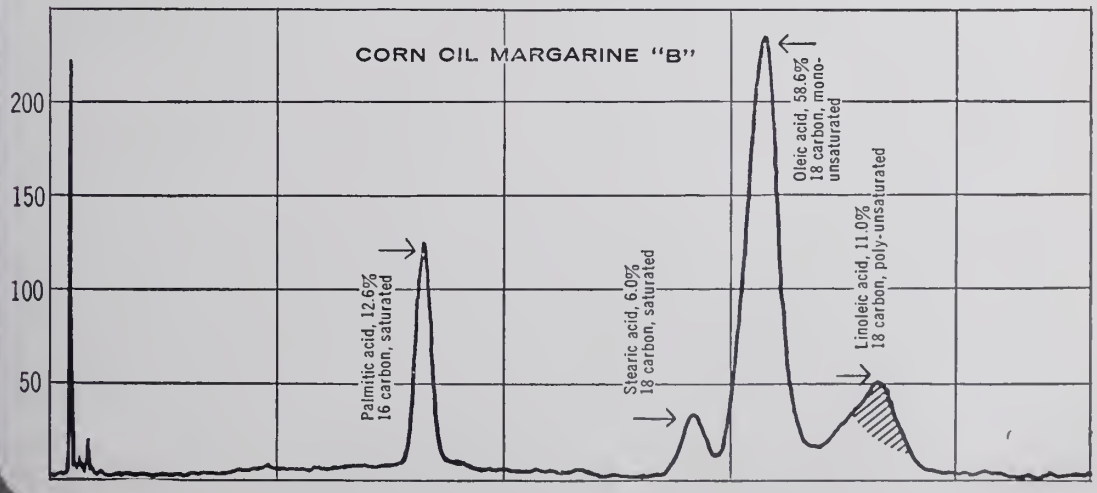
GAS CHROMATOGRAPHS *Produced by Independent Laboratory*



Note purity. Few peaks. Cleanly separated.
High Linoleic Acid Content, 52.9% Poly-unsaturated



Note effect of coconut oil. Medium Linoleic Acid Content, 37.5%



Note effect of hydrogenation. Low Linoleic Acid Content, 11%

Announcing

'ACTIFED'®

Decongestant / Antihistamine

THE POTENTIATED DECONGESTANT



provides symptomatic relief of nasal congestion and rhinorrhea of allergic or infectious origin

Many patients whose symptoms are inadequately controlled by decongestants or antihistamines alone respond promptly and favorably to 'ACTIFED'.

'ACTIFED' contains:	in each Tablet	in each tsp. Syrup
'Actidil'® brand Triprolidine Hydrochloride	2.5 mg.	1.25 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	60 mg.	30 mg.

safe and effective for patients of all ages suffering from respiratory tract congestion

DOSAGE

	TABLETS	SYRUP (5 cc. tsp.)	
Adults and older children	1	2	three times daily
Children 4 months to 6 years of age	½	1	
Infants through 3 months	–	½	

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

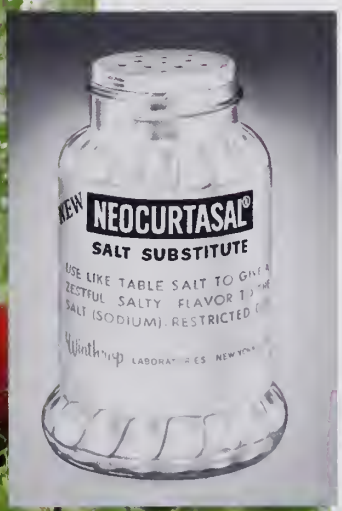
NO SALT... *but seasoned*

A meal of even the most colorful and the most meticulously prepared foo can be dreary without salt. Neocurtasal, for the patient on a low sodiu diet, brings back flavor to food and makes eating a pleasure once mor Neocurtasal is also valuable for preventing potassium deficien (weakness, etc.) in patients on diuretic therapy with chlorothiazide its derivatives.

Neocurtasal®

An excellent salt replacement fo

Salt Free (LOW SODIUM) *Die*



Neocurtasal conta potassium chlorid potassium glutam glutamic acid, calcium silicate a potassium iodide (0.01 per cent)

Supplied in 2 oz. shakers and 8 oz. bottle

Sold Only through Drugsto

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OF RHEUMATOID ARTHRITIS THERAPY

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RHEUMATOID ARTHRITIS



'hatever else may be needed from time to time
:he management of individual cases, these drugs
laquenil and Aralen] should always be given
prolonged trial (at least six months) as the
ainstay' of therapy."

Bagnall, A. W. (Univ. British Columbia, Vancouver, B.C.): A.M.A. Clinical Meeting (Scientific Section, Exhibit No. 124), Minneapolis, Minnesota, Dec. 2-5, 1958.

he 4-aminoquinoline drugs (Plaquenil and
alen) together with supplemental agents ad-
nistered in nontoxic doses effectively maintained
pression of the disease in 83 per cent of 194
:ients followed for 18 months."

Scherbel, A. L.; Harrison, J. W., and Atdjian, Martin: Cleveland Clin. Quart. *25:95, April, 1958.*

hen used in tolerated dosage and over a suf-
ent period of time, there appears to be a tre-
ndous therapeutic potential in the antimalarial
gs. . . . Plaquenil in this study did not have as
ny side effects as Aralen and thus appears to
a more practical compound."

Cramer, Quentin (Kansas City): Missouri Med. *55:1203, Nov., 1958.*

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Average Dosage:

INITIAL—400 to 600 mg. (1 tablet 2 or 3 times daily)

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reaches all nasal and paranasal membranes *systemically*[1]



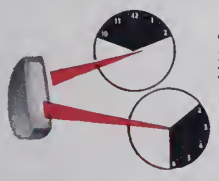
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- in sinusitis and postnasal drip
- in allergic reactions of the upper respiratory tract

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1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

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1. Lippmann, O., Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M., Am. J. Ophth. **46**:740, November 1958.

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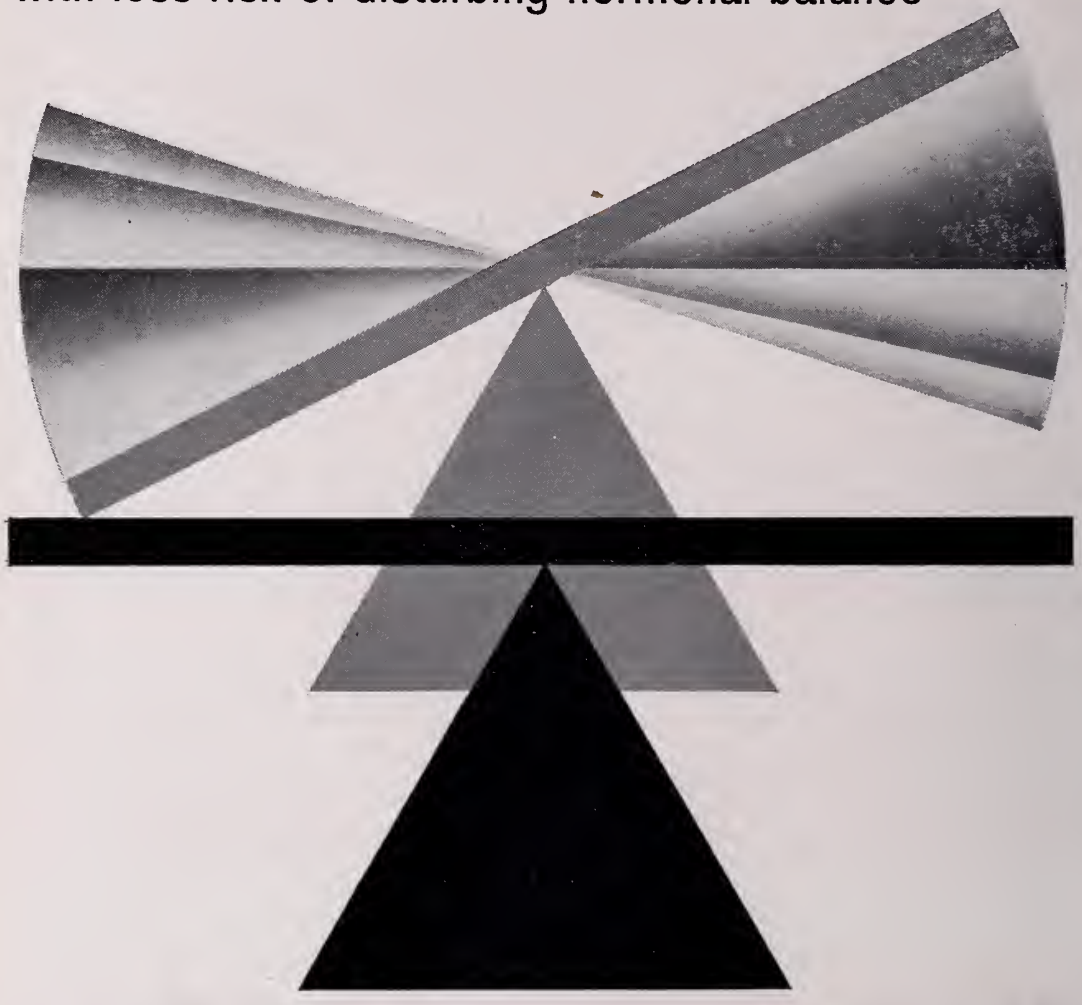
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1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

Geigy, Ardsley, New York

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1. Innerfield, L.: Clinical report cited with permission
2. Clinical report cited with permission

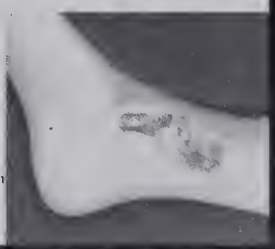
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rhus dermatitis
healed within
a week[1]





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in 3 days . . .
returned
to school . . .
ure advanced[1]





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in a week after
recurrent episode[1]





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*These common foods are among the richest sources of B vitamins and ascorbic acid. H.A. Wooster, Jr., Nutritional Data, 2nd Ed., Pittsburgh, 1954.

Allbee® with C

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RICHMOND 20, VIRGINIA

the beauty of these antitussives:



they help the cough remove its cause

These elegant antitussives comprise a group of significantly superior expectorants from which you may select the formula best suited for your coughing patient.

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In addition, the Robins antitussive armamentarium provides a choice of widely accepted drugs in various combinations with glyceryl guaiacolate for treating different kinds of coughs and associated symptoms. For antihistaminic effects, there is Dimetane® or prophenpyridamine; for bronchodilation and nasal decongestion, there are sympathomimetic agents; and for suppression of the "too frequent" cough, there is codeine or dihydrocodeinone.

Robitussin®

Each teaspoonful contains:

Glyceryl guaiacolate ..... 100 mg.

Robitussin® A-C

Each teaspoonful contains:

Glyceryl guaiacolate ..... 100 mg.
Prophenpyridamine maleate ... 7.5 mg.
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(exempt narcotic)

Dimetane® Expectorant

Each teaspoonful contains:

Parabromdylamine maleate (DIMETANE) ..... 2 mg.
Glyceryl guaiacolate ..... 100 mg.
Phenylephrine HCl, USP ..... 5 mg.
Phenylpropanolamine HCl, NNR ..... 5 mg.

Dimetane® Expectorant-DC

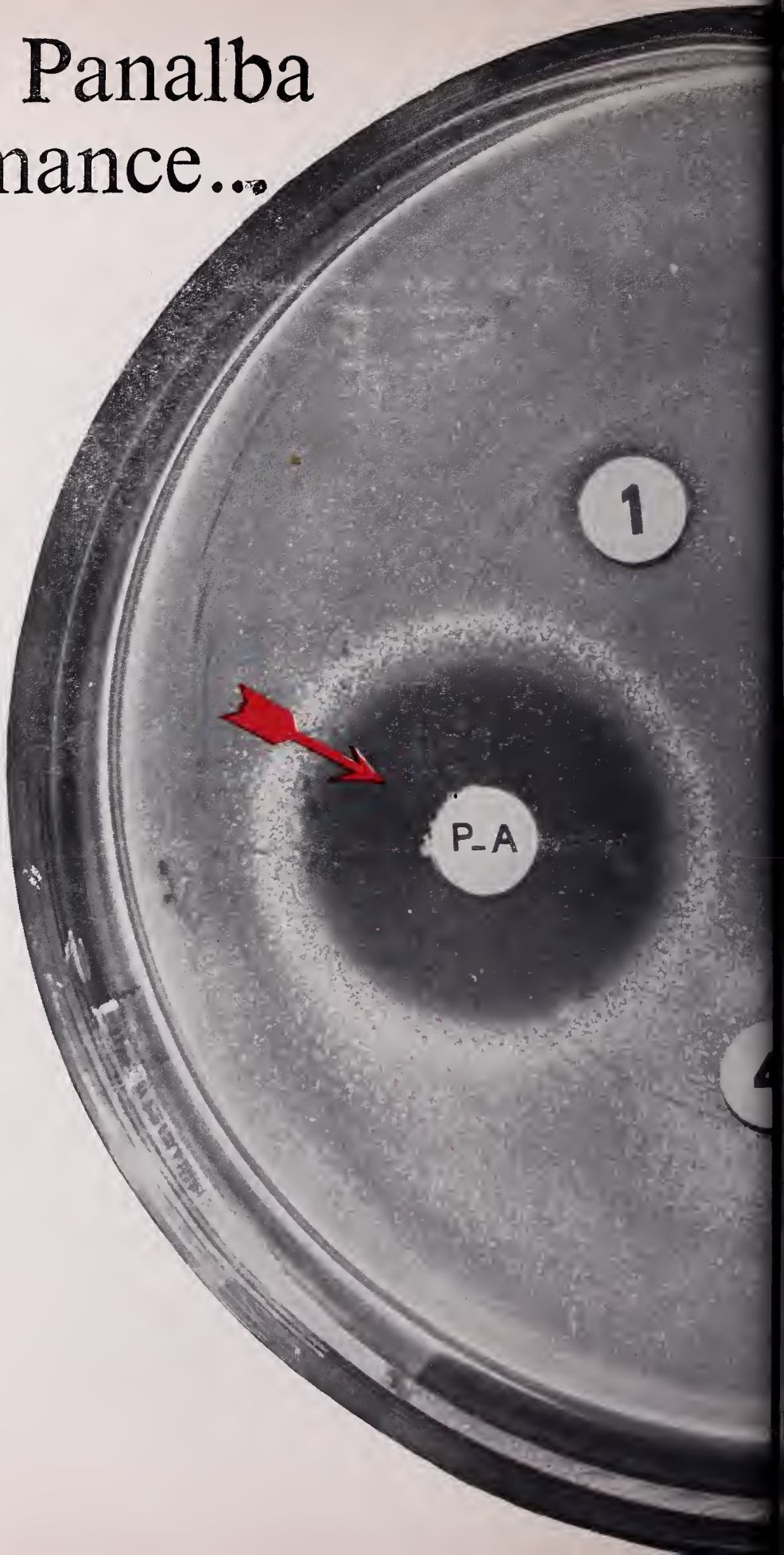
Each teaspoonful contains the Dimetane Expectorant formula *plus* Dihydrocodeinone bitartrate, NF ..... 1.8 mg.
(exempt narcotic)

References: 1. Cass, L. J., and Frederik, W. S.: Am. Pract. & Digest Treat. *2*:844, 1951. 2. Blanchard, K., and Ford, R. A.: Journal-Lancet *74*:443, 1954. 3. Hayes, E. W., and Jacobs, L. S.: Dis. Chest *30*:441, 1956. 4. Blanchard, K., and Ford, R. A.: Rocky Mountain M. J., Vol. 52, No. 3, 1955. 5. Boyd, E. M., and Pearson: Am. J. M. Sc. *211*:602, 1946.

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This is Panalba performance...





in sinusitis

. . . into a mixed culture of the four organisms commonly involved in sinusitis . . . *Str. hemolyticus, D. pneumoniae, H. influenzae* and *Staph. aureus* (in this case a resistant strain) . . . we introduce the five most frequently used antibiotics.

Twenty-four hours later (in this greatly enlarged photograph), note that only *one* of the five leading antibiotics has stopped *all* the organisms, including the resistant staph! This is Panalba.

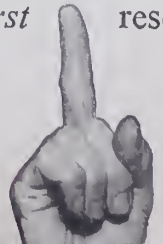
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Dosage—1 or 2 capsules 3 or 4 times a day. Supplied—Capsules containing Panmycin phosphate equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin as novobiocin sodium, in bottles of 16 and 100. *Now available:* new Panalba Half-Strength Capsules in bottles of 16 and 100.

Panalba*

(Panmycin* Phosphate plus Albamycin*)

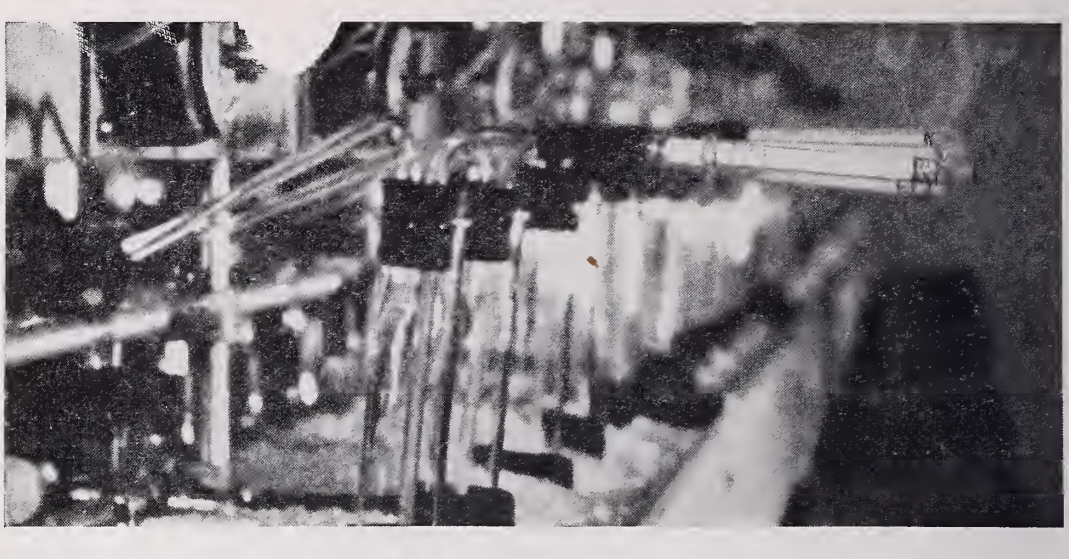
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*TRADEMARK, REG. U. S. PAT. OFF.

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A major independent research foundation, under Lorillard sponsorship, determined that the average puff of cigarette smoke contains over 12 billion semi-solid particles. Further research revealed that inhaled smoke from ordinary cigarettes has a predominant proportion of particles, from 0.1 to 1 micron in diameter, averaging 0.6 micron.

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Lorillard pioneered research into filtration—creating a filter of extraordinary ability to decrease smoke solids. So—from the very start—Kent blazed the trail in filtration. And, today, tars and nicotine are lowest in Kent's history.

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it's delicious cherry-flavored for children

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Recommended dosage: first-day dose is 1 teaspoonful (250 mg.) for each 20 lbs. body weight up to 80 lbs. For each day thereafter, ½ teaspoonful for each 20 lbs. For 80 lbs. and over, use adult dosage of 4 teaspoonfuls (1.0 Gm.) initially, and 2 teaspoonfuls (0.5 Gm.) daily thereafter. Administer immediately after a meal.

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Cause for Worry

What do doctors worry about? According to a recent report in *Medical Economics*, doctors worry about alleged weaknesses in county medical societies, how to rear children, their personal financial future, malpractice suits, the nation's "charge account economy," the worsening of doctor-patient relationships, mob violence, our indifference to poverty and disease in Asia, and the lack of group loyalty among physicians.

This is enough to keep a chronic worrier happy for years. At first glance there seems to be no common thread among these anxieties. All you apparently can say is that different people worry about different things. But on second glance a pattern emerges. Why should physicians worry more than other citizens do about poverty in Asia? About impairment of civil liberties? Somehow doctors have come to be associated with the conservative half of American society. Yet, according to this survey, their worries suggest a genuine liberalism.

The concern about alleged "weakness" at the county medical level is interesting. Delving into these answers shows that the feeling is that local medical societies are not doing all they can to improve public relations. Specifically, a number of respondents felt that the image of the private practitioner today was that of a high income man who was slow to respond to calls. Here they felt that the county medical society could take the leadership in replacing this image with the happier picture of fifty years ago. Some said that county medical societies could do more than they are now doing to lower the malpractice claim rate. For instance, one suggested approach is a willingness to fight nuisance claims. A patient asks for $300 damages. Some carriers settle at once on the theory that it is

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cheaper to do that than to spend months investigating the claim and days in court battling it. And if cheapness is a virtue this is sound reasoning. The first physician—and company—to reject a nuisance claim will lose money. But they will make it less likely that other practitioners and carriers will be victimized. All we need is someone to tie the bell on the cat.

Another thread in this pattern is a feeling that too many physicians are indifferent to social, medical and economic problems at a distance. The implication is that doctors, more than other people, ought to have so wide a zone of interest. It is a flattering if troublesome implication.

If any phrase can characterize all these yearnings, it is that here is a call for greatness, or magnanimity, or breadth of vision—call it what you will. The world is full of little people, running in their narrow ruts, concerned with their day-by-day problems, unwilling to lift their eyes to any point beyond the immediate horizon. Physicians are a privileged group—offered the chance to make a good living doing work they want to do, enjoying community prestige, and entrusted with most precious of all missions. Cognate to this privilege is a responsibility. Without seeming to preach piously, one must say that this includes a responsibility to the unfortunate of our community, if not of the world. An inability to measure up to that responsibility is cause for worry indeed.

No More Scruples

We went behind the screen in a pharmacy the other day. The apothecary handed us a little weight with a stylized "3" on it. "Recognize this?" We confessed that we didn't, though the symbol looked vaguely familiar.

"Ah" he said, "this is a scruple. Perhaps this is the last scruple in town. No one ever prescribes medication in scruple doses any more. No one ever asks me to compound a prescription by taking a scruple or two of some precious drug."

A memory slowly returned. "Twenty grains equal one scruple. Three scruples equal one drachm. Eight drachms equal one ounce."

The word itself stems from the Latin *scrupulus* meaning "small stone" reminiscent of an earlier "scrupa" for stone. Indeed, "scrotum" comes from the same word—stone. A small pointed stone was used to chip other stones, as diamonds are used to cut diamonds. So *scrupulus* became the stony little shredder. In fact the word "shred" ultimately comes from *scrupulus*—as, indeed, do "shroud," "screed" and "scrutiny." The little pointed stone became the prick of conscience (scruple in the modern sense). To the Romans it was a way of expressing the smallest weight they could use—the little piece of stone—*scrupulus*. Precious stones were weighed in units of 24—each being a carat. So other items were weighed in units of 24 (a 24th of an ounce), each unit being then a scruple. The scruple then was standardized as the 24th of an ounce—and when the drachm was developed as an eighth of an ounce, a drachm was equated to three scruples. Not until centuries later, could people handle a smaller unit—the grain.

In other parts of the Roman world, the scruple was a unit of currency (their smallest coin) and a unit of longitude (a sixteenth of a degree) and, in some places, even a unit of time.

With the dawn of the Middle Ages, man began to wrestle with his conscience. Sometimes he would be hesitant in his anxiety to determine what was right and what was wrong. The smallest matter might provoke a doubt. A less compulsive man might laugh and say that this was too trifling a matter to hesitate over. But the more conscientious person would not risk his ticket to eternal life by falling down on even the most trivial matter. Hence the word "scruple"—symbol of the smallest weight—became the word to describe the trifle that caused the troubled man to hesitate. The

word was also used in another sense. The ancients balanced their crude scales on a small sharp-pointed stone which served as pivot. So this small stone (*scrupulus*) became a term for the axis on which delicate matters could be balanced.

Here then is the rich and romantic history of an ancient apothecary's weight. They complain today that the pharmacist is a repackager of wholesale drugs. But a generation or two ago he was the heir of the alchemist; he was the artist who compounded the prescription. He did it with care, measuring every scruple, every drachm, every grain. He was precise. In both senses of the word, he had scruples.

Today's medical student knows neither the word nor its symbol. Well, we no longer need that weight. With our sterile, colorless, but efficient metric system, we can forget the drachms, and grains—aye—the scruples too—that once lent color and variety and preciseness to the ancient art of the apothecary. We can scuttle the scruple. And too often we do just that.

Ephebiatrics

The Greeks, as usual, had a word for it. Hebe, of course, means youth—for the cupbearer of the gods was the goddess of youth. *Ephebus* meant "upon entering youth" (*epi* plus *hebus*). So why not, "ephebiatrics": the study of adolescent medicine?

Two army doctors—their names are F. C. Biehusen and L. M. Hebertson—suggest that we need a new specialty: ephebiatrics. Writing, appropriately enough, in the journal of the Student Medical Association (November 1959 *New Physician*) they point out that: "... with the advent of antibiotics and modern therapeutic technics, the practice of acute pediatrics as the main mission of the pediatrician is giving way to more of a preventive practice. Well baby care, allergy, and the adolescent are examples of this changing scene.

"As the pediatrician finds the storehouse of acute disease diminishing, he looks elsewhere for professional satisfaction.

"More and more pediatricians are finding ephebiatrics a satisfying experience both professionally and personally. The ephebiatric patient is a grateful and challenging patient. He will tolerate nothing less than our full attention."

Harvard offers formal training in adolescent medicine. Few other schools do. Major Biehusen and Captain Hebertson started an ephebiatric clinic at Letterman Army Hospital. It seems that Army Regulations (with their passion for preciseness) insist that the 14th birthday separates the men from the boys, the little girls from the big girls. Thus the 15-year or 17-year old has to attend a clinic where the other patients are a generation ahead of him. So the doctors started a "teen age" clinic —but the young patients didn't like that name. Then they wanted to call it an adolescent clinic, but that made it sound all pimply and juvenile. So, the Letterman Hospital sent for its Greek letter man, who dreamt up the name "ephebiatrics."

Apart from its purely professional justification, the new specialty will avoid the catch-as-catch-can approach to the adolescent, who is too old for the serious attention of the pediatrician and too young to enchant the internist. Furthermore it will permit some physicians to focus on the very special problems of the adolescent—problems of growth, of endocrine development, of hormone production, of changes in the voice, the emotions, the hair distribution, and interests. Let the pediatrician concentrate on the little girl who plays with dolls. The ephebiatrician will concentrate on the young lad who does the same. *Ephebiatrics* is an awkward word, not yet dictionary-recognized. But, who knows? Perhaps in the next generation's medical school catalogues it will fall in its logical place between pediatrics and geriatrics. And then, someone may develop medicine for the middle aged—medieval medicine, maybe?

Original Articles • • •

FRANK J. AYD, JR., M.D.

Baltimore, Md.

Current Status of Major Tranquilizers*

Dr Ayd, a pioneer in the clinical use of tranquilizers, offers us here an amazing amount of information packed into a small space: a veritable guide-book to the use of these new medications.

THE role of chemistry in psychiatry is amply demonstrated by the new era of pharmacotherapy inaugurated by the phenothiazine and rauwolfia derivatives. These compounds indicate how chemical manipulations in the laboratory may influence mental health and even change psychiatric practice.

In recent years numerous phenothiazine derivatives have been developed by changing the halogen attached to the nucleus or by altering the configuration of the side chain. Thus, there are phenothiazine drugs with the halogen chlorine, methyl, methoxy, acetyl or trifluoromethyl. In addition, there are those with short side chains, with long side chains, and with a piperazine or piperdine ring in the side chain. All of these compounds are tranquilizers. Depending on their structure, some are weak and toxic, while others are very potent and reasonably safe.

The purpose of this report is to correlate the differential effects of some phenothiazine derivatives with their chemical structure as determined from an analysis of their clinical action in 4,000 ambulatory and hospitalized psychiatric patients who were matched for each drug studied as closely as possible according to age, sex, diagnosis, severity and duration of illness and prognosis. The minimum number of patients treated with each compound was 100. The duration of drug therapy varied from a few weeks to 5 years. The data obtained has important therapeutic implications in addition to providing a possible guide for the evaluation of future phenothiazine drugs.

On the basis of chemical structure, phenothiazine derivatives may be divided into: (1) the piperazine group, characterized by a piperazine ring in the side chain and represented by Permitil® (fluphenazine), Stelazine® (trifluoperazine), Trilafon® (perphenazine), Dartal® (thiopropazate) and Compazine® (prochlorperazine); (2) the chlorpromazine model group, characterized by a 3 carbon straight side chain and represented by Vesprin® (triflupromazine), Thorazine® (chlorpromazine), Tentone® (methyoxypromazine) and Sparine® (promazine); and (3) the piperdine group, characterized by a piperdine ring in the side chain and represented by Pacatal® (mepazine). The structural formulae are in Figure 1.

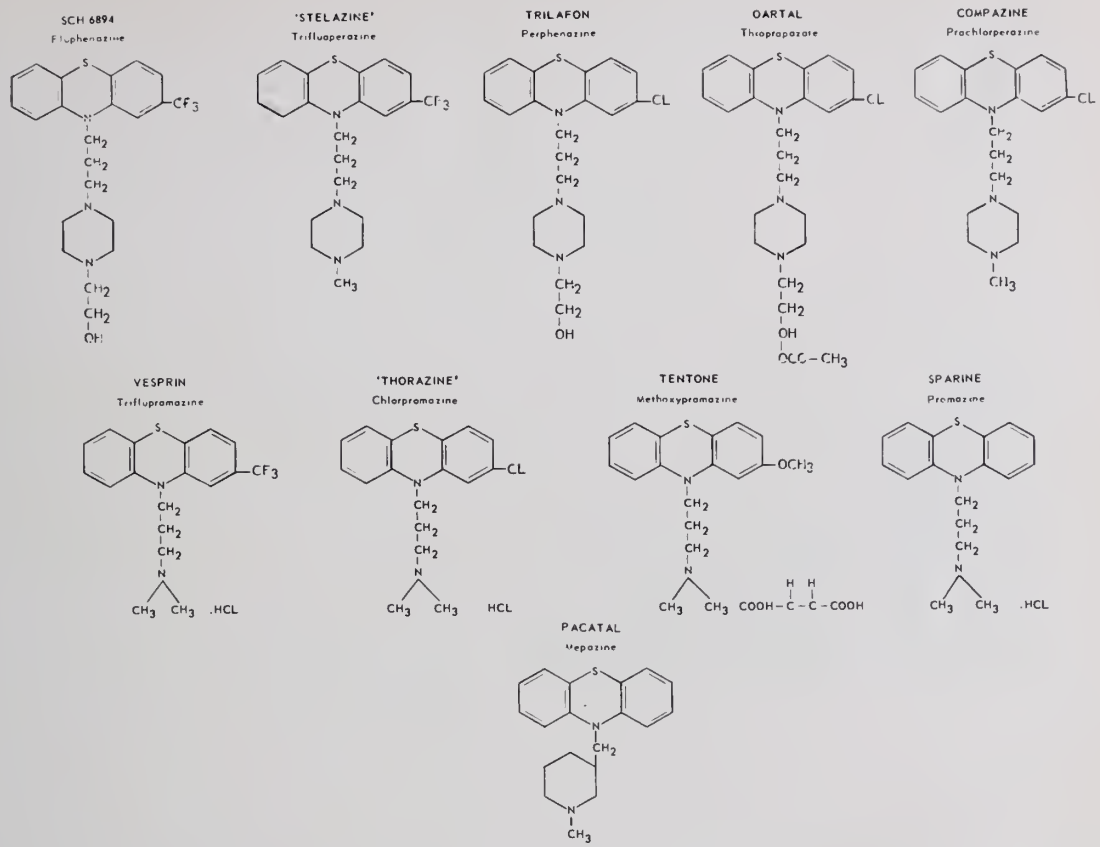
Each of these compounds exert varying degrees of behavioral effects and somatic reactions. Each group of phenothiazine derivatives differs from the other in milligram potency and in their propensity to cause particular constellations of side effects. There is also an intra-group variability in milligram potency and side reaction depending on the halogen connected to the phenothiazine ring.

The potency of each drug was determined by

*Read at the Ninth Annual Institute in Psychiatry and Neurology, Veterans Administration Hospital, Lyons, New Jersey, April 1, 1959.

1. Freyhan, F. A.: American Journal Psychiatry, 115:577 (January, 1959).

FIGURE 1.



Since this illustration was engraved, the professional designation SCH 6894 has been replaced with the trade name Permitil®.

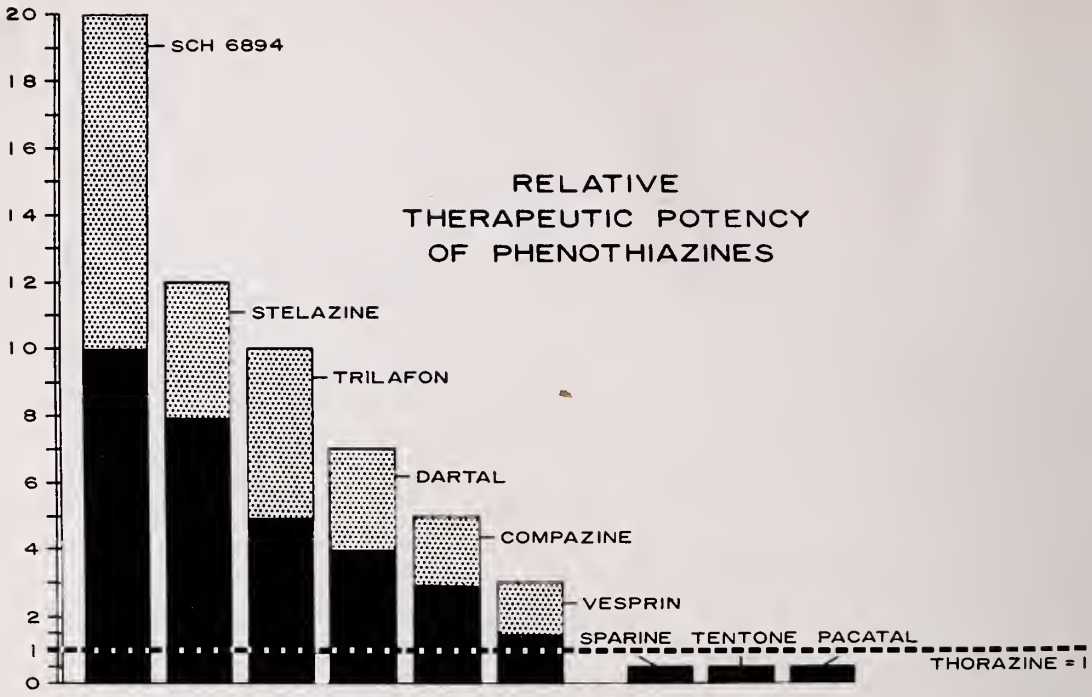
Freyhan's criteria.[1] These were: (1) the attainable level of psychomotor inhibition, (2) the speed of action, and (3) the dosage required to obtain effective action. By these standards Pacatal,® Sparine® and Tentone® are half as potent as chlorpromazine which is less potent than Vesprin.® Compazine® is 3 to 5 times, Dartal® 4 to 7 times, Trilafon® 5 to 10 times, Stelazine® 8 to 12 times, and Permitil® 10 to 20 times as potent as Thorazine®. These are graphically portrayed in Figure 2.

The milligram potency of each phenothiazine compound illustrates the relationship between this drug characteristic and chemical structure. Pacatal®, which does *not* contain a side chain with 3 carbons, is the least potent phenothiazine derivative. Promazine and Tentone® have a 3 carbon straight chain and are approximately equipotent. They are the least potent members of the chlorpromazine model group. The importance of the halogen attached to the nucleus is exemplified by Thorazine® and Vesprin®. The chlorine halogen endows Thorazine® with twice the potency of Sparine® and Tentone®. The trifluoromethyl halogen makes Vesprin® two to three times as potent as Thorazine®.

The piperazine group further illustrates the relationship between chemical structure and milligram potency. All members of this group are more potent than the chlorpromazine model drugs. This is due to the addition of the piperazine ring to the side chain. The halogen joined to the nucleus is as important as the piperazine ring in the side chain. This is shown by an experimental piperazine derivative which does not have a chlorine or trifluoromethyl halogen. This drug has a milligram potency equal to chlorpromazine which is considerably less than the milligram potency of all other piperazine group compounds. Further evidence of the importance of the halogen is offered by the substitution of trifluoromethyl for chlorine in Compazine® and Trilafon® to make Stelazine® and Permitil®. These latter drugs are at least double the potency of their chlorinated counterparts, Compazine® and Trilafon®.

Clinical experience with other phenothiazine derivatives not included in this report also supports the importance of the chlorine and trifluoromethyl halogens. Every phenothiazine drug with either of these halogens possesses greater potency than any other members of their respective groups. The trifluoromethyl halogen, in particular, endows a

FIGURE 2.



Since this illustration was engraved, the professional designation SCH 6894 has been replaced with the trade name Permitil®.

phenothiazine compound with the maximum potency so far known. This is illustrated by Permitil® and Stelazine® in the piperazine group and by Vesprin® in the chlorpromazine model group.

The effective initial daily dosage range is one indicator of the milligram potency of a phenothiazine derivative. The more potent the phenothiazine drug the smaller is its effective initial daily dosage range, irrespective of the diagnostic category or the target symptoms for which it is prescribed. See Table 1.

The dosage ranges cited in Table 1 represent averages for each diagnostic group. Since these drugs were administered to control or eradicate target symptoms, such as tension, anxiety and psychomotor excitement, there were individuals who required more or less of the drug than the tabulated averages. Likewise, because the drugs were prescribed for symptom amelioration and not for a particular illness there were numerous neurotics who needed more of a drug than psychotics.

TABLE 1.

EFFECTIVE INITIAL DAILY DOSAGE RANGE*

	Permitil	Stelazine	Trilafon	Dartal	Compazine	Vesprin	Thorazine	Sparine	Tentone	Pacatal
Schizophrenic psychoses	2-10 mg.	10-60 mg.	32-64 mg.	50-100 mg.	75-100 mg.	100-300 mg.	300-800 mg.	500-1000 mg.	500-1000 mg.	500-1000 mg.
Manic-depressive psychoses	10-20 mg.	20-80 mg.	32-96 mg.	60-150 mg.	75-150 mg.	200-400 mg.	300-1200 mg.	500-1500 mg.	500-1500 mg.	500-1500 mg.
Senile psychoses	1-5 mg.	2-8 mg.	4-12 mg.	10-40 mg.	10-40 mg.	30-75 mg.	30-100 mg.	50-150 mg.	50-150 mg.	50-150 mg.
Psychoneurotic disorders	1-5 mg.	4-20 mg.	8-24 mg.	15-60 mg.	15-60 mg.	30-150 mg.	100-300 mg.	150-400 mg.	150-400 mg.	150-400 mg.

*Initial dosage was individualized according to the severity of symptoms such as anxiety, tension and psychomotor excitement. Maintenance dosages were determined by individual requirements.

Phenothiazine derivatives may cause a variety of autonomic, endocrine, dermatologic, hepatic, hematopoietic, and neurologic side effects. The type and frequency of these reactions also are related to milligram potency and chemical structure. Autonomic side reactions, although produced by each drug, were most common with the weakest derivatives, Pacatal®, Sparine® and Tentone® and least frequent with the most potent derivatives, Permitil® and Stelazine®. Ascending the potency scale from the piperdine to the piperazine group there was a progressive decrease in endocrine effects. The most prominent endocrine effects were produced by Thorazine® which caused a polyphasia, polydypsia, polyurea, and marked weight gain in addition to altered menses and lactation. The metabolic effect of chlorpromazine became more evident the longer the patient took this drug. Fifty patients who have taken Thorazine® for 2 to 4 years gained an average of 35 pounds irrespective of the pre-treatment body weight. Pacatal® and Sparine® had less pronounced endocrine effects. Two patients had false positive tests for pregnancy while taking Pacatal.® This has also been reported[2] for Sparine®.

TABLE 2 reflects side-effects. It will be noted that dermatitis, jaundice and agranulocytosis are allergic reactions to phenothiazine drugs.[3] *Every compound in this study caused some type of allergic skin reaction.* These were more frequent with the weaker phenothiazine derivatives and were rarely caused by the members of the piperazine group. Jaundice did not occur with the drugs in the piperazine group. A recent report[4] on jaundice due to Compazine® is the only one attributed to a drug in the piperazine group. Only Vesprin® and Tentone® of the chlorpromazine model group did not cause jaundice in this study. This may be due to the small sample of patients treated since Vesprin® jaundice *has* been reported.[5] Thorazine® and Pacatal® caused the highest incidence of icterus.

Thorazine® jaundice has been the subject of intensive study. Its occurrence raised logical questions of potential adverse effects on the liver, even in the absence of icterus, especially if chlorpromazine was prescribed for a protracted period. Two groups of Thorazine®-treated patients have been evaluated. The first group consisted of 50 patients treated for 2 to 4 years. The individual minimum total dosage of Thorazine® was 54,000 milligrams and the maximum total dosage was 1,078,000 milligrams. The pre-treatment liver profiles of these patients consisting of cephalin flocculation, direct and indirect serum bilirubin and alkaline phosphatase were compared with the survey liver function studies and analyzed for any significant change which might have occurred. The formula employed was the Student's "t" Test. The values of "t" were far below those which would indicate a significant difference between the pre-treatment and the survey test results. Thus it appears[6] that

2. Foxworthy, D. L. and Lehman, R. M.: Journal of Obstetrics & Gynecology, 10:385 (October, 1957).
3. Ayd, F. J., Jr.: Journal of Nervous and Mental Diseases, 124:84 (July, 1956).
4. Mechanic, R. C. and Meyers, L.: New England J. Med., 259:778 (October 16, 1958).
5. Leger, Y.: L'Union Med. Canada, 87:831 (July, 1958).
6. Ayd, F. J., Jr.: Journal of The American Medical Association, 169:1296 (March 21, 1959).

TABLE 2.

MAJOR SIDE EFFECTS

	Permitil	Stelazine	Trilafon	Dartal	Compazine	Vesprin	Thorazine	Sparine	Pacatal
Dermatitis	0% of Cases	0% of Cases	0% of Cases	0% of Cases	0.5% of Cases	8% of Cases	6% of Cases	4% of Cases	6% of Cases
Seizures	0% of Cases	0% of Cases	0% of Cases	0% of Cases	0.5% of Cases	0% of Cases	0.5% of Cases	4% of Cases	5% of Cases
Jaundice *	No	No	No	No	No	No	Yes	Yes	Yes
Agranulocytosis *	No	No	No	No	No	Yes	Yes	Yes	Yes

* Not expressed in per cent due to very low incidence

Thorazine®, even in relatively large doses, administered over 2 to 4 years had no demonstrable deleterious effect on the liver in these patients.

The second group of 12 patients comprised those who became jaundiced on Thorazine®. Five of them continued to take Thorazine® and the icterus ultimately cleared. Other clinicians[7] have reported similar experiences. In the remaining 7 patients, Thorazine® was discontinued when jaundice appeared. After the icterus cleared, the medication was resumed and two patients had a recurrence of jaundice which was milder than the first episode. These two patients were given Thorazine® a third time without a recurrence of icterus. This indicates that the liver can be desensitized to Thorazine® as suggested by Shay and Siplet.[8]

THE effect of prolonged Trilafon® therapy on liver function has been determined in 50 patients who took this drug for 19 to 34 months. Pre-treatment cephalin flocculation, alkaline phosphatase, indirect and direct serum bilirubin were compared with the survey test results. The Student's "t" Test[9] did not disclose any significant difference between the pretreatment and the survey liver function studies. Similar results were found in 20 patients treated with Dartal® for a full year. These data suggest that these phenothiazine derivatives given over a protracted period have not had any deleterious effects on the liver.

Agranulocytosis has been caused by all piperdine and chlorpromazine model group drugs except Tentone.® This exception may be due to the small number of people treated with Tentone® thus far. To date, no verified case of drug-induced agranulocytosis has been reported in patients treated with drugs in the piperazine group. Conversely, clinical experience has shown that the frequency of this blood dyscrasia is highest with the weakest phenothiazine derivative.

7. Schneider, E. M., Daugherty, C. and DeVore, James K.: Southern Medical Journal, 51:287 (March, 1958).

8. Shay, H. and Siplet, A. B.: Gastroenterology, 35:16 (July, 1958).

9. Ayd, F. J., Jr.: New England J. Med., 261:172 (July 23, 1959).

The occurrence of agranulocytosis has raised questions regarding possible toxic effect on the bone marrow with long-term phenothiazine derivative administration. Most blood dyscrasias due to these drugs have occurred in the first few months of therapy. Thereafter they have been exceedingly rare. Fifty patients treated with Thorazine® for 2 to 4 years, 50 patients given Trilafon® for 19 to 34 months, and 20 patients on Dartal® for one year showed no statistically significant difference between their pre-treatment leukocyte count and differential count as measured by the Student's "t" Test. This implies that the prolonged administration of these pharmaceuticals is unlikely to have adverse effects on the hematopoietic system.

Convulsions may be precipitated by any phenothiazine drug, especially in epileptics; and in non-epileptics, too, if large doses are given, particularly to patients who have had many electroconvulsive treatments. However seizures are a rare side effect of the members of the piperazine group. Convulsions occur with increasing frequency as one descends the potency scale of the chlorpromazine model and the piperdine groups. Sparine® and Pacatal® have caused the highest proportion of seizures.

PHENOTHIAZINE derivatives may cause extrapyramidal reactions ranging the various manifestations of akinesia to dyskinesia, akathisia, and parkinsonism. Akinesia is characterized by weakness and muscular fatigue. It causes the patient to be almost constantly aware of fatigue in a limb used for ordinary, repetitive motor acts such as walking or writing. In advanced form the patient complains of aches and pains in the musculature of the affected limb. This may be associated with joint pains, most often in the shoulder, with limitation of motion. Patients with akinesia seem apathetic. They are disinclined to initiate or to expend the energy to complete a task. Hence there is reduction in their voluntary activity and a tendency to become dependent on others.

Akinesia is the commonest form of neuro-

logic reaction to phenothiazine derivatives—but it is seldom recognized as such. Instead, because of the patient's apathy and inertia, it is often erroneously assumed that he is sedated by the drug, even though he is alert and complains not of drowsiness but of weakness and fatigue. Akinesia may be relieved by reducing the dose of the responsible drug or by the addition of an antiparkinsonian drug such as methanesulphonate (Cogentin®) or Akineton® 1 to 2 milligrams twice daily. The removal of akinetic symptoms by an antiparkinsonian agent indicates that they are of extrapyramidal origin.

Dystonic reactions or dyskinesia are characterized by abrupt onset of retrocollis, torticollis, facial grimacing and distortions, dysarthria, labored breathing and involuntary muscle movements. This may be accompanied by scoliosis, lordosis, opisthotinos, tortipelvis and the characteristic gait of dystonia. Up to 90 per cent of these reactions occur in the first 72 hours of treatment. Because of the spasm of the neck musculature, the dysarthria and the difficulty in breathing, dyskinesia may be misdiagnosed acute encephalitis or tetanus. Dystonic reactions can be relieved promptly by the intravenous or intramuscular injection of a short-acting barbiturate or 2 milligrams of Cogentin® or Akineton®, which may be repeated in a half hour if necessary. Subsequent administration of the responsible drug should be deferred for the next 24 hours. Then the drug may be represcribed in lower doses or concomitantly with an antiparkinsonian agent, since dystonic reactions are not a contraindication to further therapy.

Oculogyric crisis is another form of dyskinesia. The attack begins with a fixed stare for a few moments. Then the eyes are rotated upwards and to the side and fixed in that position. The patient is barely able to move his eyes. At the same time the head is tilted backwards and laterally, the mouth is opened wide, the tongue is protruded and the patient's facial expression suggests pain. An attack may last for a few minutes or several hours. Prompt relief is afforded by 2 milligrams of Cogentin® or Akineton® intramuscularly. Further oculogyric attacks can be prevented by either giving lower doses of the responsible drug or by the co-administration of an antiparkinsonian agent.

Akathisia† or motor restlessness is often described by the patient as the "jitters." He feels compelled to walk or pace the floor. When sitting he constantly shifts his legs or taps his feet and complains of feeling jittery or anxious. When standing the patient may continuously rock his body forward, backward and side to side or constantly shift his weight from one foot to the other. At the same time there may be chewing movements of the jaw, a rolling or smacking of the tongue, and a twisting of the fingers. Akathisia† usually appears after the first week of treatment (earlier with the more potent drugs). The larger the dose, the more likely is it to occur. If the drug is continued akathisia† may be replaced by parkinsonism. Most patients are annoyed by akathisia† and will not tolerate it long. The fastest relief can be achieved by 2 milligrams of Cogentin® or Akineton® intramuscularly. It may also be allayed by giving either of these drugs orally twice daily, often without lowering the dose of the phenothiazine drug.

Akathisia† especially when caused by the most potent phenothiazine drugs, Stelazine® and Permitil®, is the most difficult to manage of the drug-induced extrapyramidal reactions. Frequently only partial relief is obtained with moderate doses of antiparkinsonian drugs. Larger doses are inadvisable since these drugs exert psychotropic effects of their own. Their co-administration in large doses with a phenothiazine drug may precipitate a toxic psychosis. Safer control of akathisia† is secured by the simultaneous prescription of moderate doses of an antiparkinsonian drug and small doses of a barbiturate.

Phenothiazine derivative-induced extrapyramidal manifestations are neurophysiologic and not toxic effects of these drugs. They appear to be totally reversible drug effects. It

†Some medical dictionaries define akathisia as a morbid reluctance to sit down. The word generally refers to a compulsion to pace the floor, an insistent restlessness.

is possible to control or eliminate them by reduction of dosage, mild sedation or antiparkinsonian drugs. They occur with increasing frequency, appear earlier in time and with progressively smaller doses of the drug as one ascends the potency scale from the piperdine to the piperazine groups. Thus Pacatal®, Sparine®, and Tentone® caused extrapyramidal reactions in one to two per cent of patients when the daily dose exceeded 400 milligrams. Thorazine® was responsible for neurologic effects in 34 per cent of patients when the dose was more than 300 milligrams a day. Vesprin®, in daily doses of 150 milligrams or more, induced these reactions in 36 per cent of patients. All the piperazine group compounds, except Trilafon®, produced 40 per cent or more of neurologic reactions. Trilafon® caused these reactions in 36 per cent of patients. This was due to the fact that the effective dose of this drug was below that usually responsible for extrapyramidal reactions.

TABLE 3.

EXTRAPYRAMIDAL REACTIONS

	Permitil	Stelazine	Trilafon	Dartal	Compazine	Vesprin	Thorazine	Sparine	Tentone	Pacatal
Dosage at which extrapyramidal symptoms may be observed	3 mg.+	4 mg.+	32 mg.+	40 mg.+	60 mg.+	150 mg.+	300 mg +	400 mg.+	400 mg.+	400 mg.+
Parkinsonism	10% of Cases	22% of Cases	15% of Cases	17% of Cases	20% of Cases	16% of Cases	14% of Cases	0.5% of Cases	0% of Cases	0.5% of Cases
	12%	8%	1%	2%	2%	3%	0.5%	0%	0%	0%
Dyskinesia	of Cases	of Cases	of Cases	of Cases	of Cases	of Cases	of Cases	of Cases	of Cases	of Cases
Motor restlessness	30% of Cases	30% of Cases	20% of Cases	25% of Cases	21% of Cases	17% of Cases	20% of Cases	1.5% of Cases	1% of Cases	0.5% of Cases

TABLE 3 reviews the extrapyramidal reactions.

Until Stelazine® and Permitil® were studied it was assumed that the marked increase in the extrapyramidal reactions precipitated by the piperazine group drugs was due to the addition of the piperazine ring to the side chain. That this is only partially so is demonstrated by the experimental piperazine referred to previously which causes a much lower incidence of extrapyramidal stimulation than the chlorinated piperazine derivatives Compazine®, Dartal® and Trilafon®. On the other hand Permitil® and Stelazine® which are identical to Trilafon and Compazine® (except for the replacement of chlorine by the trifluoromethyl group) cause pyramidal reactions. This neurologic datum also illustrates the importance of the halogens, chlorine and trifluoromethyl, which not only contribute to a phenothiazine derivative's potency but enhance its capacity to produce extrapyramidal reactions as well.

The older the patient the more likely are extrapyramidal reactions to occur. This is true for every phenothiazine drug as illustrated by Table 4. Seventy per cent of all extrapyramidal effects for all age groups are in patients over 50 years of age. Dystonic reactions and akathisia† happen most often in the younger patient, while parkinsonism is most frequent in the older patient. Akathisia† and parkinsonism appear 3 times as often in women

TABLE 4.

PHENOTHIAZINE TRANQUILIZERS
EXTRAPYRAMIDAL REACTIONS
AGE DISTRIBUTION

	Permitil	Stelazine	Trilafon	Dartal	Compazine	Vesprin	Thorazine
Number of Cases	70	120	180	180	198	98	234
Age Range							
0-19	0.3%	0.4%	1%	0.5%	0%	0.4%	1.8%
20-29	1.2%	1.2%	1.3%	0.2%	1.1%	1.0%	0.9%
30-39	11.8%	13.7%	13.5%	15.3%	14.9%	16.5%	13.3%
40-49	12.1%	12.3%	12.0%	13.0%	13.7%	12.1%	16.0%
50-59	32.6%	31.2%	31.8%	32.2%	29.3%	33.7%	34.0%
60-69	34.2%	32.4%	33.1%	30.2%	30.8%	35.0%	32.3%
70-79	7.8%	8.8%	8.2%	8.1%	10.2%	0.3%	0.2%
80-89	0.0%	0.0%	0.0%	0.5%	0.0%	1.0%	1.5%
Total	100%	100%	100%	100%	100%	100%	100%

as in men while dystonia occurs twice as often in men as in women.

Extrapyramidal reactions due to phenothiazine drugs are a matter of individual susceptibility even more than a matter of chemical structure, potency, dosage, or duration of treatment. In this study there were patients who never experienced neurologic effects (non-neurologic reactors) although they took the same drug in equal or larger doses, for the same length of time or longer, as those patients who developed extrapyramidal symptoms (neurologic reactors). In addition some patients had only a single neurologic manifestation while others had several.

Further evidence of individual susceptibility comes from a study in which patients classified as neurologic and non-neurologic reactors were administered each phenothiazine derivative. This experiment indicated that an individual neurologically susceptible to one phenothiazine derivative was susceptible to all phenothiazine derivatives equipotent to or more potent than Thorazine®, whereas those resistant to one were unresponsive to all phenothiazine derivatives.

That time and dosage are relatively unimportant compared to individual susceptibility is exemplified by the patients in this study. Some of them have taken more than 1000 milligrams of Thorazine® daily for 4 years without developing parkinsonism; others have taken 32 to 64 milligrams of Trilafon® a day for 3 years with equal immunity to extrapyramidal effects; and still others have taken relatively large doses of Stelazine® and Permitil® for 6 to 24 months without neurologic effects.

Is the ratio of improvement or symptomatic recovery greater in patients who developed parkinsonisms than in those who did not? In this study as many patients with parkinsonism were treatment failures as there were patients who were treatment successes without parkinsonism. This corroborates the observation of Freyhan [10] that parkinsonism does not contribute to favorable therapeutic results.

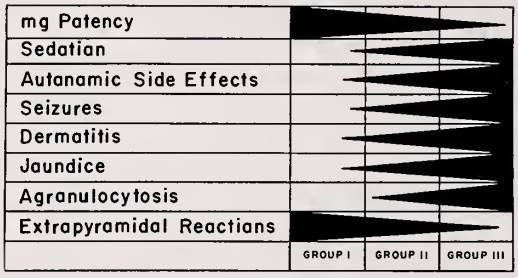
With increasing potency the phenothiazine derivatives have less sedative and hypnotic properties and (as indicated by Permitil® and Stelazine®) tend to become more of a stimulant. Likewise, increased potency means relative freedom from autonomic side effects, dermatitis, jaundice and agranulocytosis, and endocrine effects but a greater propensity for extrapyramidal reactions. See Figure 3.

These clinical observations provoke speculation regarding the sites of action of the phenothiazine derivatives in the central nervous system and the influence of the halogens chlorine and trifluoromethyl on the ability of a drug to effect receptor cells. Clinical evidence suggests that although phenothiazine derivatives have widespread actions in the body,

10. Freyhan, F. A.: American Journal of Psychiatry, 115:577 (January, 1959).

they act primarily on three neuroanatomic systems—the reticular system of the medulla, mid-brain, and diencephalon; the hypothalamus; and the limbic system, especially the amygdala and hippocampus. This surmise is based on: (1) the antiemetic action of these drugs which implies depression of the medullary reticular formation; (2) the capacity of some phenothiazine drugs to potentiate barbiturates and to sedate which suggests an effect on the mesencephalic reticular system and hypothalamic structures; (3) the autonomic and endocrine effects of these drugs which indicate the hypothalamus as the chemoreceptor site; and (4) the extrapyramidal reactions caused by these drugs which point to an

FIGURE 3.
CORRELATION OF mg POTENCY
WITH MAJOR SIDE EFFECTS



action upon the limbic system, especially upon the nuclei of the extrapyramidal system.

The weaker the phenothiazine compound the less effect it has on the limbic system, the more effect it has on the hypothalamus and the greater its effect on parts of the reticular system. Pacatal,® Sparine,® Tentone® and Thorazine® clinically give evidence of being relatively more depressing of reticular and hypothalamic structures than of the limbic system as indicated by the proportionately higher sedative, autonomic, and endocrine effects of these drugs compared to the low incidence of extrapyramidal reactions they cause. On the other hand the more potent the phenothiazine derivative the greater is its effect on the limbic system as its propensity to cause extrapyramidal signs suggests and the less is its effect on the hypothalamus and the reticular system as evidenced by its relative freedom from drowsiness, autonomic and endocrine effects and depressive drug potentiation. Permitil®, Stelazine,® Trilafon®, Dartal® and Compazine® clinically have minimal sedative activity, do not prolong the hypnotic effect of barbiturates, and cause practically no autonomic and endocrine effects. They do cause a high incidence of extra-pyramidal reactions. These facts suggest that these drugs act primarily on the limbic system and secondarily on the hypothalamus and the reticular system.

This hypothesis regarding the central sites of action of the various phenothiazine derivatives implies that the clinical effects of each drug are attributable to selective affinity for sites in various sub-cortical areas. This prompts speculation on the importance of the halogen connected to the phenothiazine ring and of the structure of the side chain. Pacatal® which has a short side chain with a piperdine ring seems to act mainly on parts of the reticular system and certain hypothalamic nuclei and practically has no effect on the limbic or extrapyramidal systems. This is also true for Sparine® which has a 3 carbon side chain and for Tentone® which has a methoxy halogen as well as a 3 carbon side chain. Thorazine® has more effect in all 3 neuroanatomic sites than Sparine® or Tentone® suggesting that the chlorine halogen enhances the action on, as well as changes somewhat, the chemoreceptor sites, particularly in the hypothalamus. Vesprin®, however, which has a trifluoromethyl halogen, affects even more the reticular system, slightly less the hypothalamic structures, and much more the limbic system than Thorazine®.

The addition of a piperazine ring to the side chain further increases the affinity of phenothiazine derivatives with a chlorine or trifluoromethyl halogen for the limbic and extrapyramidal systems and the chemoreceptor zone of the medullary reticular formation while lessening the affinity of these compounds for hypothalamic structures. The clinical effects of Permitil® and Stelazine® indicate that the trifluoromethyl halogen further enhances affinity for chemoreceptor cells in the limbic and extrapyramidal systems. On the other hand the experimental piperazine drug without the chlorine or trifluoromethyl halogen has practically no effect on the limbic sys-

tem acting more on the reticular formation and the hypothalamus. This shows that it is not solely the addition of the piperazine ring to the side chain which accounts for the action of the piperazine group drugs. The halogen attached to the phenothiazine nucleus is equally important.

The chemical structure of a phenothiazine derivative, its milligram potency and the type of side effects it causes accounts for its safety and its range of therapeutic application. Thus, when sedation in addition to tranquilization is desired, as would be the case for acute excitements, Thorazine® or Vesprin® would be the drugs of choice. When sedation is undesirable, as is frequently the case in ambulatory patients, Permatil®, Stelazine®, Trilafon® and Dartal® would be the preferable drugs.

Since there is a correlation between the dosage of a phenothiazine derivative and the frequency and the type of side effect it causes, the less of the drug needed the more likely are serious side reactions to be avoided. This is a most important clinical consideration in choosing a phenothiazine compound since serious side effects interfere with therapeutic results. This factor accounts, in part, for the divergent therapeutic results obtained with phenothiazine drugs.

CONCLUSION

THE phenothiazine drugs are not curative. They provide symptom amelioration which enables patients to conform to conventional modes of behavior, to live at home, and to work in spite of the persistence of their basic affliction. They benefit many chronically ill patients incapacitated by a variety of psychiatric symptoms which had been refractory to all previous treatment. Instead of rendering patients less productive, patients become less introspective, more spontaneous and more productive as they are freed from tortured self-concern. The improvement shown above refers to the ratio of patients who obtained this symptomatic relief. See Table 5.

To maintain the initial improvement continuous administration of these drugs is often necessary. This raises questions concerning the possible effects of long-term therapy. Can initial improvement be maintained? Will tolerance develop making larger and larger doses less and less effective? Will patients become addicted and develop withdrawal symptoms? Will such essential organs as liver, bone marrow, and kidney suffer from protracted therapy?

That initial improvement can be sustained is exemplified by the patients in this study who have taken Thorazine® for 5 years, Trilafon for 4 years, and Vesprin®, Dartal®, Stelazine® and Permitil® for two years. This has been accomplished with progressively lower rather than increasing doses of their medication. Thus, there is no clinical evidence of tolerance to phenothiazine drugs. Nor has there been any evidence of addiction to these tranquilizers. They can be discontinued abruptly, even after years of administration, without the development of withdrawal symptoms. To date there is no clinical or laboratory evidence that protracted treatment with these drugs has any deleterious effects on the liver, bone marrow, or kidney. In fact, the longer a patient takes these drugs the fewer the side effects they cause.

TABLE 5.

THERAPEUTIC RESULTS

	Permitil	Stelazine	Trilafon	Dartal	Compazine	Vesprin	Thorazine	Sparine	Tentone	Pacatal
Schizophrenic psychoses	72%	60%	70%	62%	60%	65%	68%	40%	30%	30%
Manic-depressive psychoses (manic-hypomanic)	59%	66%	70%	65%	58%	78%	75%	50%	27%	20%
Senile psychoses	78%	65%	75%	50%	50%	30%	50%	45%	35%	25%
Psychoneurotic disorders	62%	50%	52%	40%	40%	20%	40%	35%	25%	15%

The pharmacologic management of psychiatric disorders challenges the therapeutic acumen of the physician. He must choose a drug which will produce a satisfactory remission as quickly as possible with the least risk. For this reason the newer piperazine phenothiazine tranquilizers such as Permitil® and Stelazine® represent an advance over their predecessors. The more potent the phenothiazine derivative the higher the therapeutic response and the lower the incidence of neurologic manifestations and the other major side effects as equieffective doses (*e.g.,* jaundice and agranulocytosis have not been seen with Permitil,® Stelazine®, Trilafon®, or Dartal®). Thus, in the majority of cases, it appears to be advantageous to use the more potent phenothiazine tranquilizers.

6231 York Road

Hypnosis Soothes Injured Child

Writing in the November 1959 GP, an Alaska practitioner named J. B. Deisher suggests that if a child has a painful laceration or a bone fracture, the best immediate treatment may include hypnosis. Dr. Deisher points out that a light hypnotic trance will relax the child completely. From this point on, the squirming, frightened child becomes a cooperative patient. Treatment is easier and less painful. The author says that the injured child, after a good cry, will usually drop off to sleep. The child is then gently awakened and led into light hypnosis by quiet conversation. Dr. Deisher said he tells the child, over and over again, that "everything will be all right." He also applauds bravery.

In one case, a three-year-old girl had a deep gash across the bridge of her nose. When the doctor first saw her, he told her what had happened and what he was going to do, asking if it would be all right if he fixed it without hurting her. She thought this was a fine idea.

He then asked her to take deep breaths and to close her eyes. This was done several times before taking her into the emergency room.

Before the doctor cleaned her face, he put sponges over the child's eyes, telling her that this was to keep the cleansing solution out. As the soapy sponge moved over her face, he kept telling her exactly what was happening. Gradually the sponge reached the cut. The little girl was quiet even when the cut was washed with soap and water. The doctor then injected a small amount of local anesthesia around the edges of the cut. During the entire time, he kept suggesting that she would go to sleep and stay asleep until someone told her to wake up. This, plus frequent comments on what a fine girl she was and how proud her parents would be of her, put her into a light trance.

The sponges fell away from her eyes, which were nearly closed. The cut was cleaned again, removing stray pieces of gravel, and then stitches were taken. Although it was possible for the little girl to see the needle and sutures, she was absolutely motionless.

Although the local anesthesia was given as a precautionary measure, Dr. Deisher said that hypnotic anesthesia of the area was sufficient for treatment.

The acutely injured patient is a good subject for hypnosis but is completely uninterested in formal induction, the family physician said. The patient wants something done right away and subconsciously longs for magic or a miracle to "take away the hurt." With conversation aimed at diversion, and with reasurrance, the physician can lead the patient from relaxation to sleep.

Irving M. Riffin, M.D.

Upper Montclair

An Appraisal of New Induction Agents*

What's new in anesthesia? Dr. Riffin here discusses frankly four new induction agents in a practical review of their potentialities, present and future.

The search continues unabated for compounds which will take the place of Sodium Pentothal®. What are the deficiencies in thiopental which warrant the expenditure of large sums for chemical, pharmacologic and clinical research?

1. Thiopental (Pentothal®) is a slowly metabolized barbiturate, which may be found in the blood stream for 24 hours after a saturating dose has been administered. This limits its use intra-operatively since appreciation of the total dosage must be kept in mind if the patient is to awaken in some reasonable time after the operation.

2. Pentothal® is solely hypnotic in its properties. It has no analgesic effect.

3. Pentothal® has definite depressant effect on the respiratory center and on the cardiovascular system.

We will discuss four new induction compounds, three of which differ radically from the thiopental structural formula.

Methohexital®

Methohexital® is one of 2500 barbiturates prepared by the chemists of Eli Lilly and Co. It differs from previously released short-acting barbiturates in that it does not contain a sulfur atom.[1-5] It is at least twice as potent as thiopental in rats, dogs and monkeys. Comparative studies with thiamylal and thiopental in dogs (where anesthesia was controlled with an EEG servo-mechanism for three hours) indicated that anesthetic blood levels of Methohexital® were only half that of the thiobarbiturates. During recovery, its blood levels fell more rapidly. Three hours after cessation of anesthesia, only 35 per cent of the third hour anesthetic blood level remained, as compared with 75 per cent with the thiobarbiturates, probably because it is considerably less fat-bound and is metabolized more rapidly than thiopental. In the animal experiments, there were no significant differences in respiratory or cardiovascular depression.

ECG Studies. In twelve patients, serial cardiographs were run prior to, and following the administration of Methohexital® at one minute intervals throughout the operative procedure. In ten cases the tracings were normal and remained unchanged throughout the study. One showed a shifting pacemaker, not present in the control, tracing, *i.e.*, auricular premature contractions. In the one remaining case, intermittent formation of left ventricular, unifocal premature contractions were noted in several tracings. There were no other significant changes associated with this disturbance in rhythm. In conclusion, ten cases showed no effect on the ECG. In two, minor changes occurred, rapidly reverting to normal.

EEG Studies. In twelve patients, the Cam-

*Presented before Section on Anesthesiology at the 193rd Annual Meeting of The Medical Society of New Jersey, on April 28, 1959. This work is from the Anesthesiology Department of St. Vincent's Hospital in Montclair.

bridge single channel encephalograph was used in taking bi-polar recordings from the left fronto-occipital areas before intravenous administration of Methohexital® and then repeated at minute intervals throughout the operative procedure. In three instances the background rhythm showed a tendency toward a slight increase in frequency and diminution of microvoltage as an immediate presumed effect of the drug. In all twelve instances after a minimal time lapse of twenty seconds, there occurred a slowing in the background frequencies varying between two and six cycles per second with a pronounced increase in microvoltage. The recordings resumed their pretest pattern within 2½ to 5 minutes of the initial injection. On the basis of this study on twelve patients, it would seem that the effects of intravenous administration of Methohexital® on the electroencephalogram were minimal, and in all cases the records reverted to the control patterns within five minutes.

Clinical Studies. We used 40 to 50 milligrams or 4 to 5 cubic centimeters, one per cent Methohexital® for induction prior to the administration of general anesthesia. This dose is 20 per cent of the usual induction dose of Pentothal® or Surital®, and only 10 to 15 per cent of that with Neraval®. The premedication was minimal, usually Seconal® 100 milligrams and scopolamine 0.4 milligrams. The induction dose was given slowly (30 seconds) intravenously. The patient was obviously asleep within 30 to 60 seconds—quite as rapidly as with the other barbiturates. Methohexital® 40 to 50 milligrams is adequate for induction since only one patient of the 400 in this series was not asleep shortly after the administration.

Complications or adventitious side effects were infrequent. Only two of the 400 patients coughed and had mild laryngospasm. Several evinced fibrillatory movements of the face and lips at onset of sleep which persisted for about 30 seconds.

Only six were chosen for maintenance with Methohexital® and nitrous oxide 70 per cent in surgical procedures which would not require any relaxation. As with other short acting barbiturates, it seems to be purely hypnotic with no analgesic properties. However, with repeated doses or continuous drip supplementing nitrous oxide 70 per cent, the anesthetic can be satisfactorily managed, but the recovery time may be markedly prolonged, *i.e.* up to two hours.

Summary of Methohexital® Findings. This new ultra-short acting barbiturate has been used clinically. It is an excellent induction agent. It has the usual limitations for maintenance of anesthesia, but in small doses the awakening time is short. Methohexital® is a valuable asset to our pharmacologic armamentarium in anesthesia and deserves further study.

DORIDEN INJECTABLE®

DORIDEN® is completely unrelated in structural formula to the barbiturates. It is packaged in 5 cubic centimeter ampules in a viscid menstruum containing 250 milligrams. Pharmacologic investigation revealed no respiratory depression with rather large doses. We limited our observations to the 250 milligram dose. Doriden Injectable® seemed to be unsuitable as an induction agent because:

1. Slow onset of hypnosis (3 to 4 minutes). On occasion the patient was not put to sleep with this dose. Higher dosage 500 to 1000 milligrams is more effective but then the patient remains asleep for 2 to 6 hours postoperatively.
2. The high viscosity of the preparation made handling with small needles (such as 21G) impractical, necessitating a change of needles for pulling up the drug and another for the injection intravenously.
3. Local and venous irritation was prominent in our small number of cases. Inadvertent extravascular deposition of the drug was extremely painful. Three patients remarked of pain along the vein during administration.
4. The effect of the drug is too prolonged. Some of the original investigators speak of a six-hour sleep—postoperatively. Few anesthesiologists today would countenance such prolonged depression.
5. Larger amounts of drugs cause definite and marked hypotension.

In general, Doriden Injectable® was an inadequate induction agent from many viewpoints.

THE Geigy Company recently released a drug which seems to have both hypnotic and analgesic properties. For the moment, it is called G 29505 and we refer to it as Compound G. It is insoluble in water so that an organic solvent is employed which at this stage of formulation is milky white. Figure 1 shows the anesthetic effect in varying dosages, and the duration of this effect in the rabbit. Figure 2 reveals comparative analgesic effects of morphine, amidopyrine and two dosage schedules of Compound G. Note that the sensory blocking effect is definite and comparable to the narcotic.

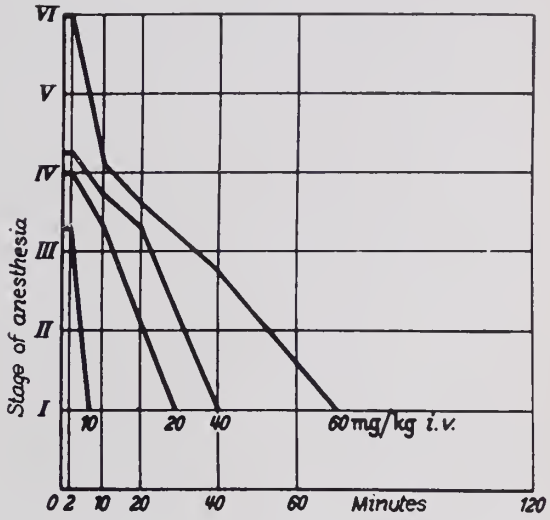
Compound G has been used in Europe for two years, but only recently has it been released for clinical investigation in the United States. The experience of our group consists of twenty-five inductions. Much of the clinical data that I will present is culled from European investigators.

A dose of 3 milligrams per kilogram or 250 milligrams for the average adult acts as an effective and rapid induction agent. Shortly after the administration, an episode of hyperventilation supervenes, which is followed by a period of apnea lasting up to 60 seconds. On occasion, the hyperventilation phenomenon is associated with guttural and snoring sounds, which is in contrast to the quiet subsidence of the Pentothal® patient. The hyperventilation appears concurrently with the anesthetic state and may be indicative either of the onset of anesthesia or may represent passage through the excitatory stage. In any case, there is complete amnesia to the phenomenon on awakening. I did not find the apneic period disturbing, and no apparent cyanosis occurred during the short interval. The hyperventilation episode recurs to a lesser degree each time the injection of Compound G is repeated.

When Compound G is used alone or with nitrous oxide, patients awaken within 3 to 5 minutes with minimal post-anesthetic sequelae such as headache, dizziness, nausea or vomiting. Blood pressure, pulse, and ECG changes are of no significance after routine doses of Compound G.

Two criticisms of Compound G are worthy

Anesthetic effect of G-29505 in the rabbit when administered intravenously as a 10% solution of propylene glycol.



Stages of anesthesia were determined by evaluating the postural reflexes described by Magnus, following a modification described by Girndt.

Figure 1

Change in stimulation threshold in rabbits produced with G-29505 compared with aminopyrine and morphine.

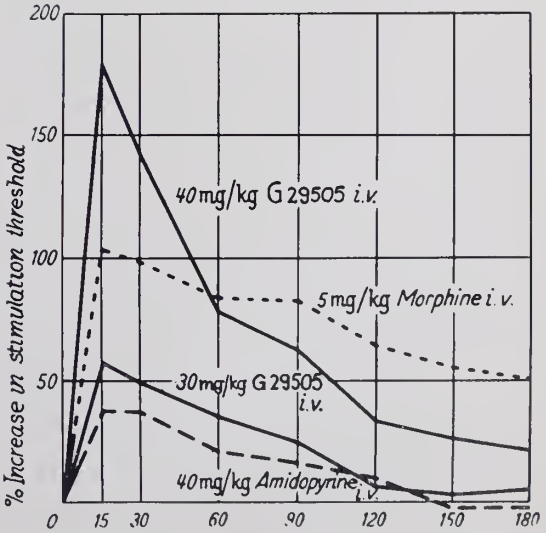


Figure 2

of note. Blood drawn back into a syringe-full of the drug is somewhat blurred by the milky white solution. This makes direct intravenous administration somewhat difficult and hazardous, in view of the fact that inadvertent extravasation causes definite local reaction of pain and erythema. Venous irritation also occurs occasionally.

Compound G is of interest as a new induction agent because of its analgesic properties, and the absence of respiratory and cardiovascular depressant effects. Further clinical investigation is certainly indicated.

THE SERNYL® GROUP

THESE drugs which were released about a year ago for clinical investigation by Parke Davis and Co. are quite interesting. They have, on occasion, profound sensory blocking properties without the depressant qualities of the narcotics. At this time, they are known as Ci 395; Ci-400; and Ci 401. In animals incoordination and flaccidity and absence of reaction to painful stimuli were the prominent observations. High dosage might cause convulsions, but lower doses were depressant in effect. Some stimulation of respiration and an elevation of both systolic and diastolic blood pressure were noted.

Method. In view of the dearth of experience in clinical anesthesia with these compounds when our group began its investigation, a simple protocol was delineated. Minute to minute observations were recorded as long as the patient was under the sole influence of the Sernyl® drugs with or without nitrous oxide 70 per cent. When other anesthetic drugs were added, the time in relation to the operative procedure was noted—and no further observations were recorded.

A dose of 0.1 milligram per kilogram was used throughout our clinical trial. No subsequent injections other than the initial dose were used. If deeper anesthesia was required cyclopropane or Pentothal® was instituted.

Clinical Experience. It was found that the patient would respond to the command "lift your head" for 2 to 5 minutes after intravenous administration. No resistance to the mask was ever noted.

The capricious and unpredictable sensory blocking effect of the Sernyl® drugs is clearly shown in the following experiences. When used with or without nitrous oxide, a potent anesthetic such as cyclopropane had to be invoked before the skin incision in 29 per cent of our cases. The reaction of the patient to washing of the surgical area with Septisol® or ether was the reason cyclopropane was used. However, two-thirds of the patients did not react to the surgical incision. In five instances, the peritoneal cavity was opened and the viscera was handled without any additional anesthetic. During a varicose vein ligation and stripping, the patient was actually conversing with the surgeon and the anesthetist. During many procedures, the eyes would roam; the lid reflex was present and the lids were tense; the brow might furrow intermittently; and the head would move from side to side.

OUR clinical observations concur with those of Greifenstein, *et al.*[9] that there is no respiratory depression after the administration of the Sernyl® drugs. Most of their patients showed a definite increase in minute and tidal volume. A similar effect was noted on the blood pressure. The changes in pulse rate were variable. Relaxation was not unusual with these drugs.

Postoperative Observations. Visual disturbances, such as diplopia and blurring are probably the most common symptoms noted after the Sernyl® drugs. These may persist from 12 hours to three days. The second most frequent postoperative phenomenon is that the patient feels as if he is on an alcoholic binge. Such comments as "My head is dizzy;" "My legs are unsteady;" "My speech is slurred;" recur in our series. Two of our patients were somewhat manic for about eight hours.

Amnesia of the operating room experience and the immediate postoperative period is quite apparent, no matter how light the hypnotic effect seemed to be.

Conclusions About Sernyl® Drugs: These

drugs have several grave deficiencies at this point in their development. These are: (1) the unpredictable and capricious sensory blocking effect; and (2) the rather frequent and annoying postoperative side effects. On the other hand, they are interesting in that the sensory blocking action is associated with respiratory and cardiovascular stimulation; and the amnesia associated with small doses is profound.

ADDENDUM

Since May 1959, 400 more inductions with Compound G have been observed. Our experiences have been favorable.

419 Park Street

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Goats' Milk in Diarrhea

When produced under modern conditions, goats' milk is free of objectionable odor and is well accepted by children. This product has more protein and less casein than cows' milk. This is also true of the fat content which is better dispersed in goats' milk. If *certified* goats' milk is specified, the practitioner—and the child—obtain a highly hygienic product.

Goats' milk (certified) was used in 100 infants suffering from diarrhea severe enough to require hospitalization. Fluids were given intravenously or subcutaneously to adjust the electrolyte-fluid balance. It was not necessary to boil the certified goats' milk. The goats' milk did not produce vomiting and thus interrupted the vomiting-diarrhea cycle. The goats' milk was considered to be exceptionally efficacious in the treatment of infantile diarrhea.

—Abstracted from an article by I. A. Budwig, M.D., *Certified Milk Magazine*, August 1959, page 6.

Early Detection in Sinus Cancer

Earlier detection of paranasal sinus-cancer may be possible through use of "tomography," a team of Houston, Texas, physicians reported in the March 1959 issue of *Radiology*. In "tomography," different layers of tissue are demonstrated on the x-ray film.

If earlier detection is not a direct benefit, the same type of radiological study still offers valuable information in guiding effective treatment programs, the report said.

Drs. Gerald D. Dodd, Lois C. Collins, Robert L. Egan and J. Raul Herrera, are the authors of this report.

Some 800 to 1,000 persons are afflicted annually with this type of cancer, the report emphasized in underlining the importance of earlier detection and better treatment planning.

Their report was based on 191 patients with the condition. Average age of the patients was 55.6 years. Twice as many men as women had the disease.

Jules Cooper, M.D.

Woodbine

William A. Davis, M.D.

Glen Ridge

Syncopal Attacks Relieved by Meprobamate:

Report of a Woman with Heart Block and Aortic Stenosis

Here, for the first time in history, is a report of the successful control of the syncopal attacks of heart block by the administration of meprobamate.

Syncopal attacks are well known complications of both heart block and aortic stenosis. For the treatment of the Adams-Stokes syndrome, in which the attacks are due to temporary cardiac asystole, a number of sympathomimetic drugs have been suggested. Little seems to be known of either the cause or treatment of fainting associated with aortic stenosis; Friedberg [1] has suggested that it may be due to cerebral arterial insufficiency associated with effort and should be treated symptomatically and by restriction of activity.

No report on the use of meprobamate for regulation of cardiac rate in humans has been published, though Arora and Sharma [2] found it effective in dogs.

That a patient with both complete heart block and aortic stenosis should have relief from her syncopal attacks after the use of meprobamate when other drugs had failed, seems unusual enough to warrant a report.

An American housewife was seen on March 8, 1943 because of a voracious appetite and weight gain of 50 pounds. She was then 54 years old.

Family History was not contributory. Her *past history* was significant only in that she had been subject to fainting spells as a young woman. As well as she could remember, these attacks had usually come suddenly without warning when she was standing up and had lasted only a minute or so after she was recumbent. They had disappeared spontaneously in middle life. Previous heart disease was denied.

Physical examination in 1943 showed a heavy woman who did not appear ill. Her height was 68 inches; weight 193 pounds, respiratory rate 20, pulse 90 and regular, and blood pressure 190/106. Her heart was enlarged to the left. A blowing systolic murmur was heard over the entire chest which was loudest along the right upper border of the sternum and the second pulmonic sound was accentuated. The rest of the examination, including urinalysis, was normal.

She was placed on a reducing diet and thiocyanate. By April, 1944 her blood pressure was 174/80, pulse 80 and weight 181 pounds. She was not seen again until June 1950, at which time her blood pressure was 154/80 and pulse 105. She said that in 1946, she had had a severe illness which she was told was rheumatic fever.

On February 22, 1955 she complained of pains in her joints. At that time, blood pressure was 220/120, pulse 70 and weight was 208. The harsh systolic murmur could then be heard over her entire chest. There were no signs of active inflammatory disease of her joints. She was placed on digitalis and reserpine as well as a reducing diet. On April 19,

1. Friedberg, C. K.: *Diseases of the Heart.* Saunders; Philadelphia, 1951.

2. Arora, R. B. and Sharma, P. L.: Effect of Quinidine and Tranquillizing Agents on Tachycardia in the Dog. Lancet, 1:962 (May 9) 1959.

1955 her blood pressure was 178/90, pulse 84, weight 205 and she had some dyspnea for which she was given a mercurial diuretic. During 1955 she gradually lost weight and continued to do her own housework. In November 1955, she once complained of a faint feeling, but examination at that time did not reveal the cause.

In 1956, however, she began to have frequent syncopal attacks which she described as "blackouts." She said, "My attacks began in September, coming as a complete surprise. While sitting on the porch with my husband and a neighbor, the first blackout came almost like a fainting spell. They soon became continuous, causing severe falls." Her husband stated that while unconcious she had convulsive movements, but recovered in a few seconds. These blackouts became so frequent, twenty or more daily, and resulted in such injuries from the falls, that she was hospitalized on October 26, 1956.

Examinations in the Burdette Tomlin Memorial Hospital showed the cardiac murmur noted previously. Her blood pressure then ranged from 230/130 to 158/74; her pulse rate was sometimes 70 to 90 per minute, at other times 30 to 40. An electrocardiogram showed *complete atrioventricular block* with a ventricular rate of 40, auricular rate of 100 and marked left axis deviation. Regitine and Wassermann tests were negative; blood sugar taken 2 hours after a meal was 117 milligrams per cent, blood count and urinalysis normal.

On rest and sedation with pentobarbital the attacks ceased, and she was discharged home on November 7, 1956 with no medication. The attacks recurred and she was given trials of different drugs. The first was mephobarbital (Mebaral®), then diphenlhydantoin (Dilantin®) and later pentobarbital (Nembutal®) which had been used in the hospital. None of these were effective in stopping the syncopal attacks. She was readmitted to the hospital on December 24, 1956. On this occasion the pulse was noted to shift suddenly from 80 to 30, and back; her blood pressure varied from 200/120 to 140/60. She was given a trial of ephedrine sulfate for several days without benefit and discharged on January 13, 1957.

During 1957 she stayed at home and suffered many syncopal attacks. Her pulse rate was always about 40 though no digitalis was given. Blood pressure was variable, at about 190/90. Trials of other drugs were made, including phenobarbital, reserpine, amphetamine, vitamin B complex, chlorpromazine (Thorazine®) and vitamin B_{12} but all without benefit. In the patient's own words "After returning home, the attacks went on as before and became so bad that they lasted for several days, one spell going into another until I didn't know anything or anybody. I remained in bed for several months, having sides on my bed to prevent my falling out of bed during an attack."

In May 1958 it was reluctantly concluded that the blackouts were perhaps intractable and irremediable and had to be accepted as such. Medications were stopped, and attention was directed merely to alleviating the anxiety secondary to her disability. Meprobamate,* in a dose of 200 milligrams per capsule in a slow release form, at 12 hour intervals was started on May 19, 1958.

Results were immediate and dramatic. Amazingly, no further blackouts occurred during the next two months, until July 14, 1956 when a single, mild, fleeting "blackout" occurred, with another such momentary episode on August 5, 1958. The patient summed up the results in November 1958 by stating, "This summer I have lived a normal life, able to do my work and do everything for myself for the first time since my attacks began." From the latter date until this writing (July 7, 1959†), no further attacks have occurred.

In May of 1959 she was living an active life, including walks of a half mile or so. She was reexamined when she returned to Woodbine for the summer, another electrocardiogram was taken, and her heart examined radiologically.

Physical examination showed no outward manifestations of illness when visited at her home on May 10, 1959. Her motions were quick and natural, her mood cheerful, and her mentality clear. She had no complaints. There was distinct arteriovenous nicking in the eye grounds. Her chest was clear of rales. A harsh systolic murmur, which was loudest in the right second interspace, could be heard over the entire chest and was transmitted to the neck. A systolic thrill could be felt in the aortic area and the cardiac impulse was heaving. The second sound was diminished in the aortic area, and one observer believed he heard a faint diastolic murmur. The blood pressure was 260/120 and the pulse 40. Thorough massage of both carotid sinuses caused no detectable change in pulse rate nor any subjective symptoms. Arterial pulsations in the feet were normal.

An electrocardiogram on May 2, 1959 showed complete heart block with an auricular rate of 100 and a ventricular rate of 40, and marked left axis deviation.

Radiologic examination of the chest (May 13, 1959) was reported as follows: "Views in AP and lateral projections reveal moderate to marked increase of the hilar markings and some fine fibrous changes extending to the extreme bases. This represents changes of chronic pulmonary congestion. No fluid is demonstrated at the bases and the diaphragm, pleura and mediastinum are within normal limits.

The cardiac silhouette is enlarged in both directions to a moderate to a marked degree. The CT ratio is 17.5 to 27 centimeters. There is sclerosis of the arch of the aorta and slight prominence of the pulmonary conus. The lateral view reveals that the right side of the heart is enlarged posteriorly and extends posterior to be almost in contact with the vertebral column. There is no concentric enlargement of the aorta demonstrated in the views included.

No added chronic changes of the lungs are demonstrated and there is no other abnormality within the thorax." The radiologist's conclusion was that the silhouette was that of a hypertensive heart rather than a rheumatic contour. The findings pointed to a silhouette and findings of beginning

*Meprospan®.

†As of October 11, 1959 when the proofs were read, there was still no recurrence.

decompensation. No active lung pathology was demonstrated.

An attempt was made to stop the meprobamate to see if the syncopal attacks would recur; but the patient refused to abandon the medication because she felt it essential to her health.

This woman obviously has both hypertensive cardiovascular disease and arteriosclerotic heart disease with complete heart block and stenosis of the aortic valve; whether she ever had rheumatic disease is questionable. It is almost certain that her syncopal attacks, which began in September 1956, are a manifestation of the Adams-Stokes syndrome.

The point of interest is that *her syncopal attacks stopped when meprobamate was given.* Absolute proof that the meprobamate was the agent which produced the dramatic improvement could not be obtained, since it would have necessitated a risk which the patient was unwilling to take. However, the time of recovery coincided exactly with the time meprobamate was given; furthermore, the patient had had frequent syncopal attacks during the previous year and a half and had no remission either when on or off drug therapy before. Therefore it seems highly probable that relief was afforded by the meprobamate, as the patient herself believes.

The reason meprobamate was helpful can only be surmised. The most likely explanation is that this woman has a hyperactive vagus reflex, subject to emotional stimulation, as suggested by her attacks of syncope when younger. By relieving emotional stress, the meprobamate may have diminished vagal tone and thus relieved the syncopal attacks.

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Harris Headache

Increasing interest is being shown in a type of migraine characterized by repeated attacks of very severe headache. Known as "Harris headache," the syndrome is discussed in an unsigned editorial in the October 31 (1959) *Journal of the American Medical Association.* Also called "cluster headache," it occurs after weeks of freedom from pain. A bout usually lasts for weeks, with the patient having at least one attack daily.

The patient is more often a man than a woman (between two and four to one) and between the ages of 30 and 50 years, although first attacks have been reported in patients as young as 11 and as old as 59.

The attacks of pain are excruciating, but their duration is relatively short: minutes to an hour. The constant boring or throbbing pain is at the outer side of the eye. It may spread to the forehead, the scalp and occasionally, the neck.

The pain usually affects the same side repeatedly, in fact, the same spot. Most attacks occur on the right side. In contrast to the more usual migraine where the patient prefers to lie down and pull the covers over his head, with "cluster headaches," he cannot recline and usually must pace. There seems to be a relationship between the pain and the muscular activity that it causes. The attacks tend to occur at the same time of day or night, most frequently between 2 and 3 a.m.

The bouts recur irregularly and then may cease after occurring for years. Most victims have previously had the more classic type of migraine, which is replaced by the Harris form.

Management starts with regular injections of ergotamine tartrate. The patient is taught to give himself the injection daily for five days each week. The two free days allow the patient to determine whether the bout of pain has ceased.

Another interesting fact about this "variant of the galaxy that is migraine" is that the patient cannot tolerate alcohol during a bout, because of alcohol's dilating effect on the blood vessels of the head.

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The Widening Scope of Tracheotomy*

An Analysis of 400 Cases

Dr. Sophocles and Dr. Atkins here challenge the traditional concept that limits tracheotomies to mechanical obstruction of the airway. As they show here, there are other conditions in which tracheotomy may be life-saving.

In some books, even those intended for graduates in otolaryngology, indications for tracheotomy are limited to relief of mechanical obstruction of the laryngeal airway. Thus, the student gets the impression that there must be a rather apparent obstruction to the laryngeal airway to justify a tracheotomy. In discussing the subject with a group of interns in a general hospital, we find that they have not seen any tracheotomies at all; or they have seen one or two done in acute laryngotracheobronchitis. Yet when we review medical journals of the last ten years, it becomes evident that the trend is to expand the application of tracheotomy; this is only a trend, however, and one that is not universally accepted.

It has been our feeling at the University of Pennsylvania that a wider scope of application should be carried out prophylactically as much as possible. In 1951, one of us [1] advised tracheotomy for the prevention of pulmonary complications in postoperative and severely debilitated patients. In a review of the literature, we find a number of papers over the last few years in which newer indications for tracheotomy have been substantiated by large series of cases and good physiologic discussions. Thus, as far back as 1943, Galloway [2] demonstrated how tracheobronchial obstruction in the poliomyelitis patient makes the lung more susceptible to atelectasis and brought out its sequelae as a result of anoxia. He emphasized the need of tracheotomy in these cases.

Morrison [3] in 1946 discussed the effects of anoxia on the central nervous system. A few years later, Taylor and Austin [4] wrote of their treatment of pulmonary complications in neurosurgical patients by tracheotomy and cited the beneficial effects obtained by prevention of cerebral anoxia.

Two papers on tracheotomy were written recently, one by Nelson and Bowers [5] and the other by Skolnik and Fornatto.[6] Both papers bring out the increasing use of tracheotomies for secretional obstruction. Nelson and Bowers[5] point out that in their group, prior to 1951, there were only scattered operations done for the relief of secretional obstruction whereas in 1955, this accounted for 77 per cent of the tracheotomies. They also pointed out that out of their group of 310 cases, about 60 per cent were done prophylactically.

The obstetrical specialty joined the movement of advocating prophylactic tracheotomy when Collins [7] and others discussed the value of the operation in eclampsia. In 36 cases where tracheotomy was performed, they felt that (as in other cerebral lesions or head

*Read April 29, 1959, at the Otolaryngology Section, Annual Meeting, The Medical Society of New Jersey.

trauma) the better airway and better oxygen absorption contributed to the improvement of their patients. Sixteen were done for convulsive toxemia, and twenty for convulsive or non-convulsive comatose patients.

Special mention should be made of Von Leden's discussion [8] of the newer indications for tracheotomy in 1952. In an excellent article, he takes up the sequelae of lower respiratory obstruction and points out the need for the removal of obstructing secretions rather than the administration of oxygen or carbon dioxide.

In a review of tracheotomies done in the last four years at the University of Pennsylvania Hospital, we found a total of about four hundred cases. Of these, only one hundred fifty cases were done for actual obstruction of the upper airway. The remaining two hundred fifty were for the relief of threatened obstruction of the airway. In the following three tables, we show the pathologic physiology of secretory obstruction of the lower respiratory system.

TABLE 1.

Accumulation of Secretions
leads to
Obstruction
which leads to
Edema
which leads to
Spasm
which leads to
Anoxia

TABLE 2.

LOCAL EFFECTS

Atelectasis
leads to
Drowned lung
which leads to
Infection in retained secretion
which leads to
Irreversible changes
including
Pulmonary abscess
and
Bronchiectasis

TABLE 3.

SYSTEMIC EFFECTS

Anoxemia caused by reduced gaseous exchange
leads to
Increased capillary permeability
which leads to
Pulmonary edema
which causes
Damage to cardiac tissues
and also
Damage to central nervous system
and to
Hypercapnea
which is
Carbon dioxide retention
which leads to
Acidosis

At our hospital, 250 consecutive tracheotomies were done as follows:

103 on the Surgical Service
14 on the Pediatric Service
44 on the Medical Service
40 on the Neurosurgical Service
24 on the Neurologic Service
15 on Bronchology and Otolaryngology
11 on all other services

The conditions which led to the tracheotomy included dozens of different diagnoses. A detailed listing is available from the authors on request.

In terms of the major obstructive mechanisms, the cases are divided as follows:

Secretory obstruction (lower airway)	69
Upper airway obstruction	67
Laryngeal nerve paralysis	6
CNS lesions	96
Cardiac catastrophe	6
Acidosis	6

Here are some typical case histories:

Case 1: A 65-year old man came to the "Accident Ward" with severe dyspnea of three days' duration associated with a parapharyngeal abscess. The swelling in the pharynx extended about the larynx and tracheotomy was obviously necessary in addition to the incision and drainage of the abscess. He had been orthopneic for 24 hours. As soon as he was placed in the horizontal position with neck extended, the additional strain and compression of the larynx with accompanying anoxia caused cessation of respirations. The tracheotomy and resuscitation were successful.

Case 2: A 72-year old man was brought to our Medical Service in coma of 24 hours' duration. He had been a severe arthritic receiving large doses of cortisone. Since onset of a respiratory infection, he had been without cortisone and was found in coma, with severe acidosis. His left lung was atelectatic and a large quantity of secretions was present in his remaining pulmonary space. His respirations were at 60 per minute; temperature 105 rectally. We were impressed by the severity of his condition and the difficulty of doing a bronchoscopy in an old kyphotic patient. We proceeded with a transverse incision over the cricothyroid membrane, intending this to be a temporary tracheotomy to be later replaced by the more permanent and more standard type, lower down. The patient became conscious in a few hours; his atelectasis and bronchopneumonia cleared up in three days and at the end of the first week, he was decannulated.

Case 3: A 37-year old woman suffered her third cerebral hemorrhage and was in deep coma, which, we feared, would be her last. With some hesitation, we agreed to do a prophylactic tracheotomy. Her respirations were deep and rapid. Rales could be heard throughout her chest. Either pharyngeal secretions or regurgitated stomach contents were filling her chest. In a few weeks, this patient was ambulatory and decannulated. Pneumonia was certainly prevented.

Case 4: A post-cholecystectomy obese patient developed very shallow, rapid respirations. Soon her chest was filled with secretions. One lung promptly collapsed and the other, developing compensatory emphysema, was compressing the trachea. Bronchoscopy and catheter aspirations were not enough to maintain an airway. Routine tracheotomy could not maintain the trachea open. To this was introduced a long plastic tube to reach the carina. Soon the atelectatic lung re-expanded and her entire picture cleared up.

Several lessons are to be learned from our experience with tracheotomies. These are presented in an outline form as to indications and conclusions.

INDICATIONS

1. To overcome obvious or threatened obstruction of the upper airway.

Examples:
- (a) Laryngeal lesions; inflammatory, neoplastic, traumatic
- (b) Head and neck lesions: trauma or surgery above or at the larynx
- (c) Tetanus, or other forms of skeletal muscle paralysis
- (d) Surgery or diseases of the central nervous system
- (e) Eclampsia

2. To overcome lower respiratory obstruction, actual or threatened. This may include:

- (a) Failure of the cough mechanism, as in postoperative pain, unconsciousness, or due to neurologic factors
- (b) Failure of other methods in removing secretions
- (c) The correction of hypercapnia or acidosis associated with respiratory problems and
- (d) The improvement of ventilation by cutting down on dead space

3. Special applications of tracheotomy.

- (a) Collapsed trachea requiring special intubations to deliver air
- (b) Prolonged use of the pneophore for resuscitation purposes
- (c) Repeated bronchoscopies for removal of encrustations and tumor tissue
- (d) Occasionally for use by the anesthetist

CONCLUSIONS

THE two hundred fifty cases reported in this paper constitute about two-thirds of tracheotomies done at the University of Pennsylvania Hospital in the last four years. These tracheotomies demonstrate:

- (1) Recognition and management of the threatened upper airway obstruction.
- (2) Recognition of both apparent and insidious lower respiratory obstruction.
- (3) Management of difficult cases which, without tracheotomy, would have had fatal terminations.

Most of our tracheotomies are done in the operating room with good airway and under adequate conditions; we are learning not to wait until this operation is no longer elective. The use of tracheotomy should be brought up to date in our textbooks and in our hospitals for today's doctors. As with other forms of surgery and clinical medicine, we must seek wider application and better understanding of this valuable instrument in the management of respiratory problems.

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Bibliography will appear in authors' reprints

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Abortion*

Pathology, Prevention, Treatment

If you count unborn babies as people, then abortion is one of the leading causes of death in the United States. Dr. Greely calls for a unified campaign against this cause of death. Emotional factors in precipitating abortion are stressed in this paper.

During recent years great strides have been made[1] in reducing the maternal and infant mortality rates. It now seems likely that we are reaching an almost irreducible minimum in both these figures. More and more attention is, therefore, being paid to fetal salvage by the treatment and prevention of spontaneous abortion. Hanley[2] has recently written convincingly on the "inalienable right of the unborn." The rights of an individual are the same before birth as they are after birth. In fact, "birth does not of itself confer humannature; it is nothing more than an event which comes at a certain stage in the development of existing human organisms. We become human at the instant of the fusion of sperm and ovum." Our attitude toward life during the embryonic stage has been influenced by religious training and various legal and economic attitudes. If we have developed a liberal attitude toward induced or therapeutic abortion, then we are naturally not going to have too much concern for saving life at this stage of development. Eastman[3] has given us an excellent historical review and summary of legal practices in different countries in regard to induced abortion. If we were to embrace the view that a life begins with the fusion of ovum and sperm, then our attitude toward abortion—spontaneous or otherwise—would be greatly changed.

With this in mind we should consider abortion as another cause of death and place it in the proper order in our death rate tables. If we accept the premise that ten per cent of all pregnancies end in spontaneous abortion, then in New York City in 1958 there were approximately 16,700 deaths from spontaneous abor-

TABLE 1.

NEW YORK CITY INFANT MORTALITY

1900-1958 INCLUSIVE

Year	Total Infant Deaths	Infant Mortality Rate Per 1,000 Births	
		Total	Under One Month
†1900-09	16,153	119.9†	Not Available
†1910-19	13,520	97.0†	36.2
†1920-29	8,755	67.9†	32.5
†1930-39	5,129	48.5†	28.4
†1940-49	3,972	28.8†	21.3
1950	3.858	24.8	19.1
1951	3,847	23.6	18.6
1952	3,980	24.2	18.3
1953	3,945	24.4	18.2
1954	3.891	23.7	17.9
1955	4,268	25.8	19.6
1956	4,052	24.5	18.6
1957	4,176	25.0	19.2
1958	4,432	26.5	19.7

†Average per year.

*Read by invitation on April 28, 1959 before the Obstetrics and Gynecology Section of The Medical Society of New Jersey at Atlantic City.

tion. Placing this in the ten leading causes of death for 1958 we see that it comes just ahead of cancer.

TABLE 2.

NEW YORK CITY MATERNAL MORTALITY
MATERNAL DEATHS AND DEATH RATES
1900-1958 INCLUSIVE

Year	Deaths	Per 1,000 Live Births
1900-09†	714†	5.3
1910-19†	684†	4.9
1920-29†	674†	5.2
1930-39†	525†	5.0
1940-49†	227†	1.6
1950	118	0.8
1951	96	0.6
1952	106	0.6
1953	105	0.6
1954	96	0.6
1955	99	0.6
1956	104	0.6
1957	107	0.6
1958	106	0.6

†Average per year.

TABLE 3.

NEW YORK CITY
TEN LEADING CAUSES OF DEATH 1958

	Deaths	Rate Per 100,000	Per Cent of Total Deaths
1. Diseases of the heart	37,164	464.0	43.9
2. Cancer	16,636	207.7	19.7
3. Vascular lesion of central nervous system	6,148	76.8	7.3
4. Pneumonia	3,719	46.4	4.4
5. Diseases of early infancy	3,604	45.0	4.3
6. Accidents	2,675	33.4	3.2
7. Diseases of liver and gall bladder	2,096	26.2	2.5
8. Diseases of the arteries	1,626	20.3	1.9
9. Diabetes	1,612	20.1	1.9
10. Tuberculosis	854	10.7	1.0
Estimated deaths from spontaneous abortion	16,698		21.1

If we consider abortion purely from the obstetric point of view, we note that it is, first, the most common complication that we have to deal with. Second, as a cause of fetal wastage, Table 4 shows that its importance far outshadows the loss among premature and full term infants—the consideration and treatment of which has given us great concern during the past few years.

TABLE 4.

FETAL WASTAGE IN NEW YORK CITY IN 1958

3,289 premature and full term, under one month

CAUSES

WHAT are the causes of spontaneous abortion? There are two main groups: (1) Those which are inevitable or non-preventable and (2) those which are preventable. Table 5 lists the possible causes in the first category. Our primary interest is in the group of preventable or salvable abortions. These are classified as due to (a) physical or (b) emotional causes.

TABLE 5.

CAUSES OF INEVITABLE OR NON-PREVENTABLE SPONTANEOUS ABORTION

1. Defective embryo
2. Abnormal fetus
3. Congenital cord complications
4. Acquired cord complications
5. Ectopic pregnancy
6. Molar pregnancy
7. Placenta previa

In the former are included uterine tumors, such as myoma or adenomyosis, uterine anomalies including bicornuate uterus[4] and the incompetent internal os, the treatment of which has recently been popularized by Lash, Schirodkar and others.[5-8] Physical trauma may also be a cause for abortion and can be produced in two ways—first by a purely *physical* means such as a severe direct blow to the uterus, or by the production of prolonged shock; second, by the association of *emotional* trauma or "shock" in which case it would come under the second category of an emotional cause.[9] Sexual intercourse and abdominal surgery could be listed as traumatic causes with a large emotional overlay. Over-exertion and fatigue are often described as causing abortion, but I believe that here too the associated emotional tension is more likely to be the precipitating factor.

Abortion in the early months can be induced by removal of the corpus luteum.[10] This occasionally occurs as a surgical error. It seems logical to assume that corpus luteum failure with insufficient progesterone secretion can be a cause for abortion. The frequency with which this occurs and its exact mechanism are not known. Nor do we understand the mechanism by which other endocrine deficiencies—particularly the thyroid—may cause spontaneous abortion.

Finally, we try to classify emotional determinants into three categories, although the mechanism of the abortive sequence may be the same in each one—especially since we do not know what this mechanism is anyway. Perhaps it works through the hypothalamus and the autonomic nervous system alone, producing vascular spasm and resultant decidual hemorrhage and premature separation of the placenta, or directly on the uterine musculature producing a miniature labor. Some authorities [11] believe that there may be an epinephrine effect causing muscular spasm, although it is well known that epinephrine will cause uterine relaxation at term. There is also evidence that this hormone has a different action on the uterus at different times and in varying concentrations. We might also conjecture that the action was through some effect on the other endocrine glands; perhaps it affects the function of the corpus luteum, the thyroid or the pituitary.

But, whatever the mechanism, there seems to be ample evidence that emotional factors are often responsible to some degree at least, for a large proportion of spontaneous abortions.[10-16] We all recognize that there are many causes for *spontaneous* abortion. But it can be shown that in the large proportion of habitual abortions there is a *repetitive process* which continues to recur with each pregnancy. Many investigators and clinicians have studied and treated these patients, and as a result, many of these patients have been treated by widely divergent methods, as seen in Table 6.[17-31] Each method has produced uniformly good results and has been able to reverse the ratio of 80 per cent abortion and 20 per cent full term to 80 per cent success and 20 per cent failure. It would seem therefore,

TABLE 6.

METHODS OF TREATMENT ADVOCATED FOR HABITUAL ABORTION

Vitamins
Hormones
Removal of foci of infection
Antiluetic treatment
Immobilization

that there must be some common denominator in all these methods which is closely allied to the enthusiasm of the doctor and the close supervision which he has given to each patient. Let us call it a form of psychotherapy. Furthermore, Squier,[10] Dunbar, and Kroger [12] have discussed the psychosomatic aspects of this problem and more recently Mann,[15] treating this group almost entirely on an emotional basis, has been able to produce the same results as with the previously mentioned methods. This is ample evidence that the *repetitive factor in habitual abortion* is largely emotional in origin. I am also convinced that many of the random spontaneous abortions are caused in varying degrees by non-repetitive emotional factors. If we wish to categorize we can safely say as a result of Mann's work, that the *habitual* abortions of emotional origin (Table 7) are due to the first emotional determinant—deep seated conflicts associated often with immaturity—which are repetitive in each pregnancy, and that the random abortions are due to every day conflicts and tensions, or sudden fears and frights—all of which fail to repeat in succeeding pregnancies.

It may be postulated that all women who abort because of emotional factors, whether

TABLE 7.

CAUSES OF SALVABLE OR PREVENTABLE SPONTANEOUS ABORTION

Physical Causes:
1. Uterine tumors
2. Uterine anomalies
3. Trauma
4. Ovarian factors
5. Other endocrine

Emotional Determinants:
1. Sudden frights
2. Conflicts associated with immaturity
3. Tensions associated with every-day problems
4. Prolonged fears

they be habitual or random, have developmental or inherited emotional faults which make them prone to stress and strain which might initiate an abortive process. Conversely, it would seem that there are women sufficiently stable and well adjusted who would be extremely unlikely to have an abortion on an emotional basis, no matter how severe the stress.

What proportion of abortions are due to emotional factors? As we have already tried to show, *almost all habitual aborters are in* this group. Hertig [32] and his collaborators [33] have found pathologic ova, embryos and fetuses in approximately 50 per cent of their abortion material. This would leave some indefinite portion of the remaining 50 per cent who could be so classified.

PREVENTION

THE treatment of spontaneous abortion starts with prophylaxis and prevention. Premarital and preconceptional examination should lead to the correction of any physical defect which might predispose to later abortion. The emotional side of this problem is so important, that we strive to create a healthier emotional environment for the embryo by (1) teaching parents to bring up their daughters to be mature and self-reliant. (2) Some type of formal instruction which might be called "Preparation for Pregnancy," which could produce as much benefit for the parturient as our "Preparation for Labor" courses. (3) Greater insistence on premarital and preconceptional interviews at which time, in addition to the physical examination, the doctor should evaluate the patient's emotional reaction to pregnancy and help create a healthy attitude. He should see the husband and evaluate his capacities, and help him to give his wife the proper emotional support during pregnancy. He can do much to create a happy emotional environment for the woman who is to bear his children. The doctor should ascertain the patient's relationship with her own family and her in-laws. What has been her work or profession? How is she going to adjust to the new job of childbearing? These and many other helpful factors could be ascertained—which would help to give her a healthier approach to pregnancy. Patients should be encouraged to see the doctor early in pregnancy. If there has been no pre-conceptional evaluation, then a similar interview with both husband and wife, as outlined above, should be carried out at this time. A strong doctor-patient relationship should be developed by more frequent visits during the early months of pregnancy. We spend too little time with the new obstetrical patient—tell her to call if she has any questions and return in a month for the next visit. For some this may be enough, but for many—and particularly the abortion prone group—this is not enough. See Table 8.

TABLE 8.

PREVENTION OF ABORTION

1. Parent education
2. Vigorous prenatal care
3. Improving doctor-patient relationship
4. Meeting the husband
5. Evaluation of the husband
6. Premarital education
7. Pre-conceptional education

THERAPY

SO FAR the treatment has been largely prophylactic. What if our first contact with the patient is at the start of a threatened abortion? Conventional methods of treatment seem haphazard and unlikely to help in the cases which might be saved. Since perhaps 50 per cent or more are unsalvable because of a defective embryo, ectopic pregnancy or mole, an early vaginal examination is important. Bed rest[34] has been shown by Diddle [35] to have *no value in the treatment of threatened abortion.* Progesterone therapy, for which we had great hopes, has proved to be of no value except perhaps as a psychotherapeutic agent. Some [36] believe that it may hasten the abortive process [10] in some cases.[37,38] Other hormones and vitamins have all had their day, but seem to have been of little value except when given with the hypnotic enthusiasm of the old time patent medicine vendor.

Due to our acceptance of emotional factors as a frequent cause for abortion there has been

TABLE 9.

TREATMENT OF THREATENED ABORTION

1. Little or no change in physical activity
2. Mild sedation
3. Reassurance
4. Early examination
5. Ascertain and remove emotional pressures
6. Frequent office visits
7. Close contact with doctor until bleeding has stopped
8. More "tender, loving care"

a gradual change from haphazard treatment by vitamins, hormones and/or bed rest therapy to one which is almost completely opposite. Previously, if bleeding was reported in early pregnancy, the patient was told to go to bed and a large assortment of expensive hormones and vitamins were sent to her from her local druggist. Now treatment is designed to allay the fear and tension aroused by the bleeding itself. She is advised to carry on normal activity. A mild sedative or tranquilizer is prescribed. The patient is given an office appointment as soon as possible—certainly within twenty-four hours. At this time it is explained to the patient that we believe bleeding in pregnancy is often due to emotional tension. Usually the patient will be able to give us a clue as to what the precipitating factor might have been. This emotional factor, if still present, should be corrected. Contrary to previous practice, a vaginal examination is done to rule out ectopic pregnancy or cervical polyp, and also to evaluate the possibility of a molar pregnancy or a missed abortion. If the pregnancy seems to be progressing normally, the patient is reassured, advised to report by phone the following day, and is seen in the office at weekly intervals until the bleeding has completely ceased. Sometimes this goes on for several weeks without any apparent effect on the pregnancy. Many of these patients need extra support from the doctors, which can be readily effected by giving them a little more attention and encouraging them to call at any time, even though they have very little to report.

What can be learned from our failures? If the bleeding is associated with pain and cramps, the patient is hospitalized with a diagnosis of inevitable or incomplete abortion. Most of these patients go on to completion under anesthesia, at which time an attempt should be made to determine whether there might have been a physical cause for the abortion. On the other hand, if there seems to have been some emotional basis, this should be explained to the patient and her husband so that the fault may be corrected or avoided in another pregnancy. Care should be taken not to develop a guilt reaction in the patient or her husband.

TABLE 10.

IF THE PATIENT ABORTS

1. Determine possible physical factors by completion or by hysterogram
2. Discover emotional causes
3. Correct the emotional factors prior to the next pregnancy

I cannot give you an adequate analysis of results. A study of the author's own obstetrical patients during the past year is of passing interest, although no conclusions should be drawn from so few cases. Table 11 shows that ten of 212 patients had bleeding during early pregnancy, but went on to term delivery. Fourteen, or 6½ per cent aborted. In 12 of these 14 patients there were strong emotional determinants which may have played a part in the abortive process.

TABLE 11.

RESULTS OF TREATMENT

212 Obstetrical patients in 1958
10 Bled during pregnancy but did not abort
14 or 6½ per cent: spontaneous abortions

EMOTIONAL FACTORS

THERE are several points which come to mind in a discussion of the emotional factors causing spontaneous abortion.

First, something should be said about bleeding after sexual intercourse during early pregnancy. Our practice has always been to ask the patient if the bleeding followed intercourse; and if so, to institute no treatment whatsoever. It is our belief that this bleeding is due to trauma to the cervix and that it

will invariably stop immediately. In fact, one patient was bleeding so heavily that she was hospitalized, but by the time she reached the hospital it had stopped completely and she was discharged on the following day. This opinion regarding intercourse is in complete variance with that of Javert,[11] who believes that sexual intercourse with orgasm is a frequent cause of abortion. He interdicts sexual intercourse entirely in his management of all pregnancies.

Second, the treatment above outlined will require a great deal more of the physician's time. His reward will be mostly in the satisfaction he will get from a good result. What more do we want, anyway?

Third, it should be pointed out that while this may be infringing on the realm of the psychiatrist, any obstetrician should be qualified to care for these patients. The services of a psychiatrist are not needed any more than are the services of a general surgeon to sew up our episiotomies and do our cesarean sections.

Fourth, more work is necessary to point out the exact mechanism of spontaneous abortion due to emotional factors, so that the treatment may become more definitive and exact.

Fifth, there is no set formula for the prevention and treatment of emotional factors in relation to spontaneous abortion. In other words, each patient must be individualized.

LOOKING AHEAD

IN VIEW of the magnitude of the problem of spontaneous abortion and the salvage of life which might be achieved by long range prophylactic methods, such as pre-marital and pre-conceptional education, should we not form a society for the prevention of spontaneous abortion? What might the result be in terms of fetal salvage and public health? Javert[11] has pointed out: "most communities have numerous societies, committees, programs, clinics, and a host of social welfare departments concerned with the health of the public. There is no society for the prevention of spontaneous abortion, nor has the United States Public Health Service taken any particular stand on its prevention. Well organized national societies are concerned with infantile paralysis, heart disease, and mental health. The American Cancer Society is a leading organization in its field, yet cancer is third as a cause of death in our population. There is an Association for the Advancement of Colored People, who constitute only 13 per cent of our national population. There are many planned parenthood associations, contraceptive clinics and adoption agencies. There is a society for the prevention of blindness, and even a society for the prevention of cruelty to animals. Only a few programs are in existence for the preparation for parenthood. Such widespread acceptance of the abortion incidence is to be decried. Industry curbed the accident rate of the working man by various safety-first programs. The same thing can be done for pregnant women."

In addition, a better understanding of preventive measures and treatment should also help in the prevention of prematurity.

SUMMARY

1. Spontaneous abortion ranks with heart disease and cancer as a leading cause of death.

2. The causes of spontaneous abortion have been outlined.

3. It is believed that emotional determinants play a major role in the cause of this condition.

4. Although we have learned a great deal from the treatment of habitual abortion, our goal should be the prevention of threatened abortion and therefore habitual abortion.

5. A radical change is advocated for the treatment of threatened abortion.

6. Results of treatment seem to indicate a measure of success.

449 East 68th Street

An extensive bibliography of 38 citations will be found in Dr. Greeley's reprints.

Sidney Friedenberg, M.D.

Camden

Wegener's Granulomatosis

Report of a Case

Wegener's syndrome is a rare—and fatal—form of vasculitis. The case here reported is the first one on record which began with a lesion in the external ear. Diagnosis is hard to make before biopsy, but it is important to keep this serious possibility in mind.

Wegener's granulomatosis was first described in 1931 as a variant of polyarteritis nodosa. It differs from polyarteritis nodosa in that the vessels attacked are the smaller ones. It is the involvement of the respiratory tract (rare in periarteritis nodosa) particularly sinusitis or a lung nodule which first calls for medical care.

Wegener's granulomatosis is a *clinical* diagnosis applied to an acute, generalized vasculitis with necrotizing granulomatous involvement of some portion of the respiratory tract.* Glomerulitis and a skin rash are also prominent features.

The etiology of acute vasculitis is unknown. Since it is related to periarteritis nodosa and hypersensitivity angiitis, there is a strong feeling that it may be related to modern drug therapy and therefore iatrogenic: not only the antibiotics but the thiouracils are suspect.

Differential diagnosis includes (a) the granulomatous diseases such as tuberculosis, blastomycosis, histoplasmosis, lymphopathia venera, and others, (b) sarcoidosis, (c) granulomatous ulcerations of nose and face (midline lesions), (d) periarteritis nodosa and hypersensitivity angiitis.

Prognosis is grave and treatment is ineffective. If the diagnosis could be made at an earlier stage, before so much renal and cerebral damage is done, the corticosteroids might help.

In the patient reported below, the diagnosis of pulmonary tuberculosis by the many specialists: x-ray, diseases of the chest, and internists, was set aside only by biopsy of the skin. This statement is made not to denigrate them but to point out the difficulty in the diagnosis of an exceedingly rare disease; and to show that early biopsy of a stubborn sinusitis, for example, might ameliorate a tragedy, inevitable though it may be at this time.

A 45-year old woman was first seen in May 1958 complaining of an erythema of the tragus of the left ear. This was thought to be a contact dermatitis from the chromium of an earring. Treatment was slightly prolonged but she recovered in five weeks. In September she had a left otitis externa which proved stubborn; but by November, after full amounts of antibiotics systemically and locally, this apparently cleared. At this time she began complaining of painful, swollen joints which lasted no more than 48 hours. A severe bulbar conjunctivitis (later an irido-cyclitis) appeared which never remitted. There was no weight loss, anemia, nor fever at this time.

She was admitted to the hospital on December

*Fahey, J. L., *et al.*: American Journal of Medicine, 17:168 (1954). Excellent photographs are shown in this article, but these are essentially *clinical* pictures. Good *pathologic* details are shown in the "Case Records of the Massachusetts General Hospital," published in the November 27, 1958 issue of the New England Journal of Medicine (259:22).

11, 1958. X-rays of the lungs on admittance showed cavitation in the apices and right middle lobe which was confirmed by tomographic studies. Confirmatory evidence of pulmonary tuberculosis however, was lacking. Five gastric washings were negative for acid-fast bacilli and the tuberculin skin test was negative. Skin tests for the various pathogenic fungi and trichinella were also negative.

Many laboratory studies were carried out including those for lupus erythematosis and rheumatic fever but there were no significant findings except for the following: a greatly increased sedimentation rate of 107 (Westergren), a normal white cell count with a 20 per cent eosinophilia, a total blood protein of 6.7 Grams with a globulin of 3.7 Grams. The urine showed a moderate proteinuria and 16 erythrocytes per high powered field.

In her two-week stay the patient required codeine for her joint pains. The disease remained apparently stationary. She was permitted to return home for the Christmas holidays. While home, after only 36 hours of phenylbutazone she developed a generalized, discrete, maculo-papular erythematous skin eruption (later becoming necrotic). She then returned to the hospital.

This time, in addition to the streptomycin, PAS, isoniazid regime, corticosteroids were suggested but not begun until the report of a skin biopsy was received. This proved to be "acute vasculitis" and a diagnosis of Wegener's granulomatosis made, and intravenous hydrocortisone given in large amounts. The patient, however, became uremic, went downhill rapidly and died on January 3, 1959.

Necropsy confirmed the diagnosis of acute vasculitis. The lung cavities were proved to be necrotic granulomas. The kidneys showed arteritis and diffuse glomerulitis.

SUMMARY

A BIOPSY specimen report of acute vasculitis with the clinical findings of acute arthritis, granulomatous involvement of the lungs, and evidence of an acute glomerulitis fulfilled the criteria for the diagnosis of Wegener's granulomatosis in this patient. Necropsy confirmed the diagnosis.

This is the first reported case where the onset was apparently in the external ear which may or may not be of some significance.

2990 Alabama Road

Exaggerated Radiation Dangers

In the April 1959 issue of *Radiology*, Paul Hodges, M.D., writes:

"Even in animals, to say nothing of man, it remains to be shown that fractional body doses of the magnitude involved in roentgen examination increase the leukemia rate. We are justified merely in saying that it is within the realm of *possibility* that the tissue dose delivered in extensive and repeated roentgen examinations involving major portions of the body may possibly increase slightly the chance the patient will develop leukemia.

"During the making of a 70-mm chest microfilm at the University of Chicago, the average adult male receives a testicular dose of 0.05 milliroentgen. If this male had been living in a frame house in San Francisco and chose to visit Denver and stay there in a brick hotel for 3.6 days, the increased background from cosmic rays and the radioactivity of stone, brick and mortar would add a testicular dose of the same amount. If he climbed Pikes Peak and sat for a while on a rock, the dose would be even larger. No one has sponsored or should sponsor legislation requiring all of us to live in tents or frame houses at sea level, and it is not likely that even radiation fanatics believe that boys should be required to refrain from scaling Pikes Peak and sitting on a rock to admire the view."

Edward W. Webster, Ph.D., a radiation physicist from Boston, adds:

"The hazards of diagnostic radiography to the patient, even by the most pessimistic standards, are small. They are low enough to be outweighed by the expectation of a small potential benefit. The somewhat larger genetic hazards of most examinations are surpassed by those accruing from wearing a radium-dial wrist watch and, apparently, from wearing trousers.

"In the case of mass chest surveys, a comparison of benefit and damage is theoretically possible; a preliminary consideration indicates a large balance of benefit if well-coned x-ray apparatus is used."

Historical Article • • •

Lucy Aiello, M.T.

New Brunswick

Pioneer Contributions to Intracardiac Study

> . . . *"The beginning of the physician's secret is knowledge of the heart's movement and knowledge of the heart."*
>
> . . . *Papyrus Ebers,* 1552 *B.C.*[1]

Pioneers in the development of intracardiac studies and their important contributions to science have often been banished to bibliographic oblivion. Since the earliest attempts at the practice of medicine as a healing art, laboratory scientists have been working quietly, patiently, and often, anonymously to translate and elucidate the "heart" of cardiac dynamics. Progress in this field was greatly hampered by superstition and by the fear of religious reprisal. The heart was generally considered the "seat of the soul." Gradually the "black magic" and often cruel animal experiments have evolved into valuable diagnostic tools for the family physician as well as the cardiac surgeon.

The history of intracardiac study is marked by three major eras: The *descriptive* era dates to early anatomists who had only gross pathologic specimens to study. During the *mechanical* era cardiac dynamics and their relationship to the mechanics of circulation were defined. In the *physiologic* phase, technics evolved which measured pressures, changes in heart volume and blood flow.[2]

In his pursuit of hemodynamic investigation *William Harvey* (1578-1657) demonstrated the circulation of the blood and analyzed the heart's action. Harvey postulated the relationship of arteries and veins to the heart with reference to transportation of blood. A contemporary of Harvey's, *Richard Lower,* in his "Tractatus De Corde" (1669) emphasized the hydraulic system[3] of the circulation with the heart "acting like a piston." This work was amplified by *Adam Christian Thebesus* who also described the coronary valves and intraseptal channels.[4]

Stephen Hales,[5] the eighteenth century English minister-scientist, made notable contributions to cardiac research with his extensive studies on the intravascular dynamics of animals. Ironically, he once modestly remarked, "It may be wondered at, that one who neither by profession nor inclination . . . should engage in a thing of this nature; especially in an age and nation that abounds with ingenious persons . . . who have brought the art of preparing and injecting the finer capillary ves-

1. The papyrus was written in 1552 B.C. The most accessible modern translation is in *Classics in Arterial Hypertension* edited by W. W. Nowinski, and published in 1956 by Charles C Thomas of Springfield, Illinois.

2. Eddlemann, E. E.: Clinical Research Proceedings, 5:1 (January) 1957.

3. Nowinski, W. W.: *Classics in Arterial Hypertension.* Springfield, Illinois, 1956. Thomas. Page 5. In the preface to Stephen Hales' paper.

4. Leake, Chauncey, D.: *Some Founders of Physiology.* Washington, D. C., 1956. American Physiological Society.

5. Hales, Stephen: In the Nowinski compilation, *op cit.* reference 3 above.

sels with proper coloured ingredients to a good degree of perfection."

In the middle of the nineteenth century, *Dr. Jean Faivre* recorded arm and leg arterial pressures in human patients, besides extending the studies on animals as described by Hales.[5] He also devised cardiac catheterizations on animals and his data are similar to that of present day catheterization studies! Faivre used a metal sound and passed it through the jugular, vena cava, right atrium, and right ventricle. In another experiment he made an incision into the chest of the animal, explored the pulmonary artery with fingers and took pressures via a trocar.[6]

The first direct studies[7] of cardiac output were done on a horse in 1896. The right heart was directly cannulated by introducing a sound into the jugular veins.

Although venous catheterization in humans was developed by *Forsmann* in 1929 it was used only occasionally until *Cournand* and *Ranges,* in 1941 made it practical. Subsequently, other groups of investigators in the United States began to employ it regularly as a diagnostic aid in the study of congenital and acquired heart and pulmonary diseases.[8]

6. Pages 67 through 71 of *Classics in Arterial Hypertension,* reference 3 above.

7. Grollman, A.: *The Cardiac Output in Man.* Springfield, Illinois, 1932, Thomas. Page 10.

8. Bierman, H. R.: *Clinical Cardiopulmonary Physiology* (edited by B. L. Gordon). New York. 1957. Grune and Stratton. Page 157.

Cardiopulmonary Laboratory, St. Peter's Hospital

New Medical Index System

On January 1, 1960, there was instituted a new program for indexing the 220,000 medical articles which now appear every year. The system requires the mechanization of the index and will speed up reference service to physicians.

Dr. Frank B. Rogers, director of the National Library of Medicine, said the new operation would "lift scientific and medical documentation to new heights of efficiency and usefulness. Physicians will come to know eventually that the National Library of Medicine and the American Medical Association can jointly perform a real service to all who work close, hands and heart, to the problems of disease."

The American Medical Association will discontinue its "Quarterly Cumulative Index Medicus." This Index served as an invaluable aid to physicians, teachers, editors and writers, students and libraries since it was started in 1916.

The "Current List of Medical Literature," published by the National Library of Medicine, will be expanded to include currently published medical periodicals not covered in the past by either the National Library or the A.M.A. The new list will get a new-old name, however. It will be called *Index Medicus* so that doctors will continue using the familiar designation. The new "Index Medicus" will be published monthly by the National Library of Medicine, and will be available through the Superintendent of Documents, Government Printing Office, Washington 25, D.C.

The A.M.A. will publish annual cumulated volumes of the new index, which will be known as the "Cumulated Index Medicus," beginning with 1960. The A.M.A. will bear the cost of publishing the "Cumulated Index Medicus." In publishing this index the A.M.A. will use cumulative copy, in the form of film negatives, prepared and furnished by the National Library of Medicine.

The mechanized system will revolve around a new type camera capable of photographing text material at the rate of 230 cards per minute. The camera reduces printing costs and speeds up production which is all important because of the pressing need by physicians to have notice of current literature as quickly as possible. The savings incurred in the production operation make it possible to expand coverage to currently published medical periodicals not presently covered by any index.

Proposed Amendments to the Constitution

For your information there are submitted below several proposed amendments to the Constitution.

The amendment to Article IV, Section 2 would define "immediate past-president."

The proposed amendment to Article IV, Section 4 defines terms of office for delegates.

The proposed amendment to Article IX indicates that if a vacancy occurs in the office of President-Elect it will not be filled by the Board of Trustees.

The proposed change in Article XII clarifies the process of submitting an amendment to the Constitution.

The texts follow:

Current

ARTICLE IV—ORGANIZATION OF THE SOCIETY

Section 2 — Fellows

The Fellows are the Past-Presidents of this Society.

Any member of this Society, not already a Fellow, who is elected President of the American Medical Association, shall at the completion of his term, become a Fellow of this Society.

Section 4 — Delegates

(a) *Apportionment and Election.* Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at any meeting prior to March 31 of the fiscal year by a majority ballot of the members present. Each delegate shall be elected for three (3) years. Each component society shall be entitled to at least three (3) delegates.

ARTICLE IX—OFFICERS

SECTION 2 — Election

The Officers shall be elected by ballot at the second session of the House of Delegates at the annual meeting. No member shall be eligible for more than one (1) office at the

Proposed

ARTICLE IV—ORGANIZATION OF THE SOCIETY

Section 2 — Fellows

Add the following footnote:
(The "immediate past-president" is that living past-president between whom and the presidency no succeeding living past president intervenes.)

Section 4 — Delegates

(a) *Apportionment and Election.* Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at any meeting prior to March 31 by a majority ballot of the members present. The term of office of each delegate shall be for three (3) administrative years and shall begin on April first next following his election. Each component society shall be entitled to at least three (3) delegates.

ARTICLE IX—OFFICERS

SECTION 2 — Election

The Officers shall be elected by ballot at the second session of the House of Delegates at the annual meeting. No member shall be eligible for more than one (1) office at the

same time, except the President, the President-Elect, the First and Second Vice-Presidents, the Secretary, and the Treasurer, who by virtue of such offices are at the same time members of the Board of Trustees. A vacancy in office occurring between annual meetings may be filled by the Board of Trustees until the next regular election.

ARTICLE XII—AMENDMENTS TO THE CONSTITUTION

A. *Procedure for First Year*

1. Submission of the proposed amendment in writing, through the Secretary of this Society, to the Standing Committee on Revision of Constitution and Bylaws and to each component society by the Board of Trustees, the Judicial Council, or a component society, at least three (3) months before the annual meeting.

same time, except the President, the President-Elect, the First and Second Vice-Presidents, the Secretary, and the Treasurer, who by virtue of such offices are at the same time members of the Board of Trustees. A vacancy in office, except that of President-Elect, occurring between annual meetings may be filled by the Board of Trustees until the next regular election.

ARTICLE XII—AMENDMENTS TO THE CONSTITUTION

A. *Procedure for First Year*

1. Submission in writing of an amendment proposed by the Board of Trustees, by the Judicial Council, or by a component society to the Secretary of this Society not later than February first.

2. Transmission by the Secretary of the proposed amendment to the Standing Committee on Revision of Constitution and Bylaws and to each component society not later than February 15.

(Renumber balance—paragraph 2 becomes 3, etc., ending with paragraph 10 becoming 11.)

Trustees' Meeting: November 15, 1959

The following representatives were designated by the President since the last meeting to serve as indicated:

Dr. Wegryn—to attend the meeting of the Citizens Committee for College Opportunities in New Jersey, October 8, as an observer.

Dr. Allman—to attend the annual banquet of the New Jersey State Nurses' Association, October 29, as the President's representative.

Dr. Mahoney—to attend the State Planning Conference on Mental Health, November 12, as the Society's representative.

Dr. Mahoney and Dr. Garber—to attend the Public Hearing of the New Jersey State Commission on Mental Health, December 9 as observer. Dr. Garber, or a member of the Special Committee on Mental Health designated by him—to attend the Demonstration *re* Physically Handicapped, October 16.

Dr. Hahn, Dr. Eckstein, and Mr. Nevin—to attend the Pre-Conference Planning Session, Baltimore Regional A.M.A. Conference on Aging, November 20.

Dr. Jennings, Dr. Jehl, and Dr. Hudson—to attend the Governor's Conference on Children and Youth, November 7.

HEALTH CARE OF THE AGED

In a communication to Dr. Blasingame, Executive Vice-President of the A.M.A., it was recommended that the A.M.A. take steps to investigate—on a broad scale—the validity of the hospital administrators' claims concerning current hospital costs and the consequent impossibility of effecting reduction in costs for hospital services to persons over sixty-five in the circumstances specified.

No reply has been received to date.

CURRICULUM FOR SCHOOLS OF NURSING

The New Jersey Board of Nursing requests a meeting with representatives from our Society to discuss the revision of the curriculum for schools of nursing. It was agreed that representatives to the meeting with the nurses be named by the President. Dr. Bowers appointed:

Ralph M. L. Buchanan, M.D.; Royal A. Schaaf, M.D. and Edwin H. Albano, M.D.

WHITE HOUSE CONFERENCE ON AGING

The President has accepted an invitation from the Governor to serve as a member of the New Jersey State Advisory Committee—". . . To aid in State planning, we are asking organizations concerned with the aging to cooperate with the program and share their thinking with us . . ."

Mrs. Rowohlt, President of the Auxiliary, has been invited to serve on the committee as has Mrs. Rauschenbach, a former President of the Auxiliary and a member of the State Division of the Aging.

Dr. Blaisdell reported there would be four meetings with the subject of medical care being discussed at the meeting to be held in Glassboro at which time the Medical Society should be prepared with a positive statement.

It was generally agreed that the Medical Society should take a positive position on the matter of aging.

VISITING NURSES AND WELFARE CASES

The Visiting Nurses Association of Somerset Hills has requested that a representative of the Medical Society attend a meeting of that organization before the Commissioner of Institutions and Agencies in support of the nurses' request for payment in the care of welfare cases.

Dr. Donnelly expressed the opinion that the care of the indigent is primarily a community problem. Visiting nurses are paid by the community and their services are supported by the local United Fund, and the matter should be dealt with on a local basis.

Dr. Greifinger moved—seconded by Dr. Donnelly, and carried—that the Association be informed that because the Board does not have sufficient information to take an official position, it cannot send an official supporting representative to the meeting as requested.

BOARD REFERRALS TO HOUSE

To insure that the position of the Board will be emphasized concerning significant matters contained in its report to the House of Delegates, the committee recommended, and the Board concurred, that specific resolutions dealing with such significant matters and setting forth the position of the Board be submitted by the Board to the House.

PUBLIC STATEMENTS BY PHYSICIANS

The Executive Officer presented the following resolution which he had prepared after consultation with several of the officers and members of the Board—in accordance with Board action on September 20, 1959: That a resolution be drafted for consideration of the Board at its next meeting, for the purpose of introducing it at the Dallas meeting urging the A.M.A. in the interest of public relations to exercise every effort to prevent physicians from making public statements which are not accurate and which are factually unsound.

> Whereas, much undeserved disrepute has of late accrued to the profession of medicine and its members in consequence of the injudicious utterances and observations of both authorized and self-constituted spokesmen and critics; and
>
> Whereas,—since in many instances the utterances and observations consisted of untruths or half-truths—the sum effect has been undeservedly to depreciate the standards and character of medical and surgical services in the United States, and to discourage public confidence in them; and
>
> Whereas, among its proper responsibilities the American Medical Association should exercise every effort to exalt and protect medical and surgical practice and practitioners; therefore be it
>
> Resolved, that this House of Delegates direct the American Medical Association to strive for and maintain such rapport with all agencies and specialty groups in and of the profession as will lead to regular consultations with the A.M.A.'s Division of Communications, so as to insure that the remarks and writings of all authoritative and quasi-authoritative spokesmen will at least be consonant with fact and truth, and therefore consonant with the genuine best interests of the profession and the public.

This resolution was approved and the N. J. Delegates to the A.M.A. instructed to introduce it at the Dallas meeting next month.

EYE CARE ON FUNDED BASIS

The special committee has reviewed the "pilot" plan proposed by the Special Committee

on the Conservation of Vision, the minority report submitted by a member of that committee, and the action of the New Jersey Academy of Ophthalmology and Otolaryngology (November 15, 1959) opposing the proposed plan. The reviewing committee could find no fault in the proposal and believe it will work to the benefit of ophthalmologists. The main objections are mainly on the basis of "government" medicine, but the contents of the plan show no true evidence of this.

The special committee recommended that the Board of Trustees go on record as approving the proposed "pilot" plan as submitted by the Special Committee on the Conservation of Vision.

Upon motion by Dr. Jehl—seconded by Dr. Bowers, and carried—the recommendation was approved

UTILIZATION OF HOSPITAL FACILITIES

It is the recommendation of the liaison committee to the two parent organizations that a joint recommendation be made—by The Medical Society of New Jersey to medical directors, and by the New Jersey Hospital Association to administrators—that every hospital in New Jersey establish and maintain a "Committee on Admissions and Discharges."

It was agreed that to assist the hospitals in carrying out this recommendation, a copy of the Pennsylvania guide (Guide to the Establishment and Functioning of a Medical Staff Utilization Committee) be supplied with any other materials that might be mutually accepted as of possible value for the realization of the project. This recommendation was approved.

HOSPITAL-PHYSICIAN SPECIALIST RELATIONSHIPS

The New Jersey Hospital Association presented a statement on "hospital-physician specialist relationships," with the request that the Medical Society consider formal concurrence.

Dr. McCall pointed out that the statement does not clarify the long battle of the pathologists and radiologists to establish their own identity, it leaves the hospitals in a strong position so far as the pathologists and radiologists are concerned. To concur in the statement would place the Board in the position of assuming responsibility for going along with the hospitals against radiologists and pathologists. The statement was received and noted.

U. S. CHAMBER OF COMMERCE

An invitation has been received for the Medical Society to become a member of the Chamber of Commerce of the United States, at annual dues of $50. The communication points out that "over the years the A.M.A. has urged the individual physician to become active in the program of the Chamber of Commerce. . . . More than 650 local, state, and national associations are now members of the National Chamber . . ."

Dr. Allman moved—seconded by Dr. Wegryn, and carried—that the Medical Society take membership in the National Chamber at annual dues of $50; and that the Executive Officer report the new membership in the *News Letter*, and that the Board looks with favor on individual physicians joining, if they wish to do so.

TREASURER'S REPORT

Dr. Schretzmann's report was read and approved. The Medical Student Loan Fund account, which is in a Savings and Loan Association, had a balance of over $10,000 and the Treasurer asked permission to invest $10,000 from this account in U. S. Treasury Bills. This request was approved.

TECHNOLOGICAL SERVICES

In accordance with the directive of the Board of Trustees (May 17) and the 1959 House of Delegates, the Council on Legislation restudied the problem of technical services by non-professional personnel, taking into consideration the proposed amendment to the Medical Practice Act (approved by the Board on April 12), the action of the House of Delegates (referring the matter back for further study), and the statement before the House by the President of the Radiologic Society of New Jersey (which was instrumental in having the item referred back for further study).

It was the opinion of the legislative analyst and the Council that the reference committee and the President of the Radiologic Society erred in their statements and conclusions. What they were misconstruing are questions of law and not of fact. The proposed amendment was originally passed upon by the Society's legal counsel from the standpoint of law.

The matter was referred by the Council to the Society's counsel for opinion as to the validity of the "legal protestations" offered by the Radiologic Society.

The Council unanimously reaffirmed the amendment as previously proposed and adopted, and urged that it be processed as originally planned. The amendment reads:

Medical Practice Act—45:9-21 (k)

A chiropodist, professional nurse, *medical or x-ray technician*, or a graduate physio-therapist, masseur, electro-therapist, or hydro-therapist, while operating in each particular case under the specific direction of a regularly licensed physician or surgeon. This exemption shall not apply to such assistants of persons who are licensed as osteopaths, chiropractors, optometrists or other practitioners holding limited licenses.

MSP PAYMENT TO CHIROPODISTS

The Council re-studied this in accord with the directive of the 1959 House of Delegates that there be further study on rescinding the 1953 amendment to the Enabling Act, which made it mandatory for MSP to include chiropodists in the Plan. On recommendation of the Council on Legislation the Board took action that the amendment to the 1953 Enabling Act *not* be repealed because advantages enuring to the Society from *not* repealing the law in question outweigh the possible benefits to some few of its members if the law were repealed. The House indicated its dissatisfaction with the 1953 amendment and called attention to its action in 1958 requesting MSP to continue the limitation of its payments to those holding a full license to practice medicine.

The Council reaffirmed its original recommendation, *not* to attempt repeal of the 1953 amendment. There would be danger of other groups' attempting to amend our corrective legislation for purposes of weakening or altering the Enabling Act to their advantage. There would likewise be danger that antagonists of medicine would seize upon an attempt to repeal the supplement to the Enabling Act as motivated by selfishness and venality, and constituting a brash curtailment of benefits to subscribers with no concomitant reduction of premium costs. The Council is therefore of the opinion that public relations-wise, it would be foolhardy to attempt to get the 1953 amendment repealed.

The Council requested that the Board concur in the recommendation that the Medical Society *not* attempt to repeal the 1953 amendment to the Enabling Act.

NON-PARTICIPATING ANESTHESIOLOGISTS

Referred by the Board to the Council on Medical Services for study and report was an item from the Judicial Council concerning allegations of overcharging by anesthesiologists and the lack of participation in MSP by anesthesiologists. It was the opinion of the Judicial Council that the situation is dangerous.

At its meeting on November 1, 1959, the Council on Medical Services received the following reply from MSP:

"According to our records 59 per cent of the doctors we list as specializing in anesthesiology are participating with Medical-Surgical Plan of New Jersey. This figure does not necessarily mean that 59 per cent of the membership of the New Jersey Society of Anesthesiologists participate. Our figure includes any physician who completed a questionnaire form indicating that his specialty was anesthesiology regardless of whether or not he is a member of the New Jersey Society of Anesthesiologists."

In view of the above reply, the following recommendation was unanimously adopted for presentation to the Board of Trustees:

Inasmuch as an investigation proves that there is more than one participating anesthesiologist in Medical-Surgical Plan of New Jersey, and inasmuch as the complaint is a question of fees, the Council on Medical Services *recommends* that this be referred to the Grievance Committee of the component society in the county where the complaint originated. (Mercer)

HYPNOSIS

In compliance with the directive of the Trustees calling for a study of entertainment hypnosis—the chairman discussed the item with the Special Committee on Mental Health. The special committee unanimously endorsed the resolution, and went on record as favoring a law which would prohibit entertainment hypnosis in New Jersey.

The following is a joint recommendation of the Council on Medical Services and the Special Committee on Mental Health:

That legislation be enacted to prohibit the practice of entertainment hypnosis in the State of New Jersey.

Upon motion by Dr. Kaufman—seconded by Dr. Schretzmann, and carried—the recommendation was approved and referred to the Council on Legislation.

COMMITTEE ON CHILD HEALTH

Recommendation: That The Medical Society of New Jersey sponsor a one-day "Symposium on Physical Education Participation and Athletic Injury Prevention" in which representatives of the

New Jersey State Department of Education, New Jersey State Department of Health, Parent-Teacher Association, School Coaches, and School Physicians should be invited to participate.

It is hoped, with such a symposium as a standard, that smaller group discussions will be set up in each county under the auspices of the component society.

Upon motion by Dr. Ware—seconded by Dr. Schretzmann, and carried—the recommendation was approved with the understanding that the special committee would arrange the details of the symposium.

The State Department of Education is considering a revision of the recommendations for pupil examinations. A controversial item in the recommendations concerns emotional problems.

Recommendation: That The Medical Society of New Jersey request the Director of the Office of Health, Safety, and Physical Education, State Department of Education, to clarify the disposition of Emotional and Mental Health Problems.

All such cases should be reported to the school physician for direction to the proper diagnostic and treatment facilities, and all reports should be returned to the school physician and the designated family physician for interpretation to the proper school facilities.

Upon motion by Dr. Allman—seconded by Dr. Bertha, and carried—the recommendation was approved; the official liaison between the Society and the Department of Education, Dr. Jennings, was delegated to present the recommendation to the Department.

In the lack of any new evidence of deleterious effects of fluoridation in the recommended dosage, the special committee reaffirmed its desire for the application of fluoridation.

Recommendation: That The Medical Society of New Jersey reaffirm its endorsement of water fluoridation for the prevention of dental caries.

Upon motion by Dr. Allman—seconded by Dr. Schretzmann, and carried—the recommendation was approved; Dr. Wegryn voted in the negative.

The special committee is of the opinion that there is need for closer association between the medical profession and school coaches.

Recommendation: That the Special Committee on Child Health be empowered to contact the New Jersey Association of School Coaches and to offer to provide speakers at its annual meetings.

Upon motion by Dr. Ware—seconded by Dr. Bowers, and carried—the recommendation was approved.

COMMITTEE ON MENTAL HEALTH

In connection with its study of the resolution concerning entertainment hypnosis, the special committee felt a far more important problem was hypnosis given as therapy without medical supervision. The special committee requested, and the Council on Public Health approved, that it discuss this problem in the near future.

COMMITTEE ON CANCER CONTROL

One of the approved projects of this special committee, carried over from last year, was the publication of articles on recent advances in the diagnosis and control of cancer in The Journal of The Medical Society of New Jersey. The committee recommended, and the Council on Public Health approved, that this project be dropped. It is felt it is a duplication of effort, except in the case of an original paper written by a member.

FACILITIES FOR ALCOHOLICS

A member of the Council on Public Health recommended that an investigation be made of the facilities in New Jersey for the hospitalization of alcoholics. The Council referred the item to the Special Committee on Mental Health for study and report inasmuch as much data on such facilities is already available through the Joint Division on Alcoholic Control of the State Departments of Health and Institutions and Agencies.

FREE SERVICES BY PHYSICIANS

The Council on Public Relations reveiwed a recent article in *Medical Economics* which reported "how much doctors give away" in its consideration of the referral from the Board of the recommendation from the Special Committee on Conservation of Vision that the Council "assemble information on the services contributed to the public by physicians in clinics in New Jersey and to publish the information as a public relations project."

On the basis of the following conclusions, the Council recommended that the proposal be rejected: a membership survey would not be accurate since only a small return would be received; the time and paperwork would be voluminous; it might generate antagonistic reactions among adversaries; many lay people give of their time and services in charity with-

out extra credit; the public is aware of the charitable services of physicians; and the potential public relations disadvantages in publishing the survey results outweigh any advantages the Society and its members might gain.

The Council pointed out that the article from *Medical Economics* would carry more weight by virtue of its objective and disinterested character, and it was recommended that the article be called to the attention of the membership through the *Membership News Letter.*

Upon motion by Dr. Bowers—seconded by Dr. Buchanan, and carried—the recommendations of the Council were approved.

AUTOMOBILE DECALS

As requested by the Board that the Council consider and report on a suggestion that the Society provide decals for distribution to the membership for use on their automobiles as identification that they are M.D.s and members of the Society, the Council reported it is willing to prepare a satisfactory decal and submit quotations, if the Board so authorizes.

The format of the decal was outlined for the Board's information with the proposal that each member in good standing receive two decals and additional decals could be purchased at cost.

Dr. Bowers moved—seconded by Dr. Kautman, and carried—that the Council on Public Relations be authorized to obtain the decals, that two decals be sent to each member, and that additional decals be supplied to members upon request without charge.

COOPERATION IN LEGISLATIVE CAMPAIGN

(1) As a means of cooperation to influence support of the position of medicine on national legislation, such as the Forand Bill, the Council recommended that a group of no more than 16 speakers, composed of outstanding and competent persons of the Society and its Auxiliary, be formed; and that the group selected be called to Trenton for a day-long indoctrination session.

Upon motion by Dr. Greifinger—seconded by Dr. McCall, and carried—the recommendation was approved.

(2) The Council requested permission to explore the possibilities of preparing a concise brochure which would sum up the case against the Forand Bill in language that would be understandable and convincing to average voters; the brochure to be made available in bulk to the membership for distribution in their offices, and to be used at meetings addressed by representatives of the Society.

Upon motion by Dr. Kaufman—seconded by Dr. Greifinger, and carried—the request was approved.

DIAGNOSTIC OUTPATIENT SERVICE AND HSP

The following resolution, adopted by the Hudson County Medical Society on November 3, 1959, was received by the Board of Trustees:

> Whereas, the Blue Cross contemplates coverage of diagnostic Radiology and Pathology services to be done in the hospital on an outpatient status; and
>
> Whereas, this encourages the hospital to participate in the private practice of Medicine and places the hospital in direct competition with the private practitioner of Medicine and what is more important to all practitioners of Medicine will further the encroachment of Socialization into the private practice of Medicine; and
>
> Whereas, this will increase the cost of Blue Cross coverage to the public; therefore be it
>
> Resolved, that the Hudson County Medical Society go on record as opposing this plan; and be it
>
> Resolved, that the Hudson County Medical Society request The Medical Society of New Jersey to go on record likewise as opposing the aforesaid plan; and be it further
>
> Resolved, that a copy of this resolution be sent to each component county society for approval.

Upon motions by Dr. Gardner and Dr. Donnelly, this resolution was endorsed.

PUBLIC HEALTH ASSOCIATION

For the Board's information, the secretary reported that the New Jersey Health and Sanitary Association and the New Jersey Council for Local Public Health Services had merged on October 2, 1959 and the new organization is known as the "New Jersey Public Health Association." The membership of the two former associations will form the membership of the new association. Dr. Wegryn was the Society's official delegate, Mr. Nevin his official alternate, to the former organizations and will continue in these capacities to the new association.

A.M.A. TRAVEL QUESTIONNAIRE

Recently a questionnaire on "Physician Travel" was sent by the A.M.A. *News* to a limited number of members throughout the country. It inquired about travel within the past year, contemplated travel within the next year, method of travel and agencies used. Dr. Donnelly reported he had received such a

questionnaire. He questioned the value of the information which might be received. He objected to being asked to supply personal data of this type without knowing how and where the information would be used. Inquiry to the A.M.A. *News* did not elicit a satisfactory explanation.

Dr. Donnelly moved—seconded by Dr. Greifinger, and carried—that the Board of Trustees recommend to the Editor of the A.M.A. *News* that questionnaires, such as the recent one on travel, be discontinued and discouraged; and that a copy of the communication be sent to the Executive Vice-President of the A.M.A.

HEALTH CARE OF THE AGED—MSP CONTRACT

Dr. Bowers reported that the special subscription contract, developed by MSP for people over sixty-five having modest resources or low family income, had received the approval of the Department of Banking and Insurance. A letter to the membership, over the President's signature, has been prepared, soliciting the signatures of participating physicians for the new contract. He requested permission to sign the letter for reprinting and distribution.

Upon motion by Dr. Schretzmann—seconded by Dr. Kaufman, and carried—the President's request was approved.

Obituaries • • •

DR. JOHN F. BALDWIN

At the untimely age of 53, Dr. John F. Baldwin, a prominent Bergen County psychiatrist, died at his home on November 25, 1959. Dr. Baldwin received his M.D. degree at Georgetown in 1932. A diplomate of the American Board of Psychiatry and Neurology, he received the Silver Jubilee Award from Georgetown in 1957. Dr. Baldwin was a member of the American Psychiatric Association.

DR. CHARLES L. BROWN

The premature death of Dr. Brown on December 4, 1959, was a shock to all of us and a blow to medical education in New Jersey. Dr. Brown was dean of the Seton Hall College of Medicine, and indeed, one of the founders of that school—New Jersey's only medical college. Born in Illinois in 1899, Dr. Brown received his M.D. degree in 1921 from the University of Oklahoma. His career was one of medical teaching. He was an internist (a Board diplomate, in fact) as well as an administrator. He taught at Harvard, at Temple and at the University of Michigan. Before coming to New Jersey, he was dean of the Hahnemann Medical College of Philadelphia. He had been chief of medicine at the Boston Children's Hospital during his Harvard service, and chief of medicine at Philadelphia General Hospital some years later.

DR. EMANUEL DENHOLTZ

Dr. Emanuel Denholtz, one of the founders of the Irvington General Hospital, died after a brief illness at the age of 69. Born in Newark, he was graduated in 1913 from the medical school of the University of Pennsylvania. He then moved to Irvington and soon felt the need for a hospital there. In 1924 he joined nine other physicians to organize what is now the Irvington General Hospital. Dr. Denholtz outlived all the other founders, and with his death on November 13, 1959, the last founder of I. G. H. has passed away. Dr. Denholtz also devoted himself to working with the Irvington Home for the Chronic Sick, and was affiliated actively with the Essex County Medical Society. Dr. Denholtz was interested in all phases of medicine, and was proud to be called a "family doctor."

DR. WALTER HAYDEN

One of Ocean County's senior practitioners, Dr. Walter Hayden, died on November 20, 1959, at the age of 71. Dr. Hayden won his M.D. at the University of Pittsburgh in 1911. He interned there at the Allegheny General Hospital and later did graduate work at Wills Eye Hospital in Philadelphia. In 1929 he came to New Jersey and became physician to the County Jail which he actively served until the day of his death. Until 1954, Dr. Hayden was ophthalmologist at both the Paul Kimball Hospital in Lakewood and at the Point Pleasant Hospital. He served in all offices of the Ocean County Medical Society and was twice elected president of that organization.

DR. KENNETH L. JORDAN

Dr. Kenneth L. Jordan, director of orthopedics at Montclair's St. Vincent's Hospital, died suddenly on November 11, 1959. Born in 1920, he was graduated in 1945 from New York University's College of Medicine. After interning at St. Clare's Hospital in New York, he enrolled in the Navy and served in the Medical Corps there. On being demobilized, he took a residency at the Crippled Children's Hospital in New York and later at Duke University Hospital in Durham, North Carolina. In 1955, he was certified by the American Board of Examiners in Orthopedic Surgery. He was also an FACS. Dr. Jordan was consulting orthopedist at the Overbrook Hospital in Cedar Grove, and was on the staff at Mountainside Hospital and the Crippled Children's Hospital.

DR. FRANK LEHMACHER

Dr. Frank Lehmacher, one of our Society's golden merit laureates, died in Lakewood on November 20, 1959. Born in 1878, he was graduated in 1902 from the College of Physicians and Surgeons of Columbia University. He did general practice at first, but became increasingly interested in physical and rehabilitative medicine and was a pioneer in those fields. Dr. Lehmacher had been medical director of the physical therapy department at Lenox Hill Hospital in New York. After moving to Lakewood, he reorganized the physiatric services at the Paul Kimball Hospital there and became director of that department. He was also placed in charge of Ocean County's center for orthopedic rehabilitation.

DR. GENE LUONGO

Dr. Gene Luongo of North Bergen died on November 16, 1959 at the untimely age of 46. He had been born and brought up in Hudson County. In 1952 he won his M.D. degree at the University of Bologna. During World War II, he was a medical officer in the Navy. In his younger days, Dr. Luongo was a well-known football player, first at the high school, then at the college level. He functioned later as a football coach at Memorial High School and then at Bergen Junior College. A general practitioner, with interest in internal medicine, Dr. Luongo was affiliated with both the Jersey City Medical Center and the North Hudson Hospital.

DR. BERT W. ROY

One of New Jersey's senior practitioners died on November 17, 1959 with the passing that day of Dr. Bert W. Roy. Born in New York in 1878, Dr. Roy was graduated in 1908 from the Albany Medical College. He soon moved to Sussex County, New Jersey and served the people of that area for half a century. He was active in the affairs of his county society and served several terms as president of the Sussex County Medical Society. Dr. Roy took time out from a busy family practice to serve as a medical missionary for his church in India, and was honored by the Indian government for founding a hospital at Ramipet Tai in that subcontinent.

DR. EMILIE V. RUNDLETT

On November 17, 1959 at the grand age of 83, Emilie V. Rundlett died at the Jersey City Medical Center to which she had dedicated so much of her life. Born in South Carolina as Emilie Viett, she was graduated in 1901 from the medical school of that state—the first woman ever to earn an M.D. degree there. A few years later she married Dr. Henry Rundlett, a distinguished New York physician who brought her to the New York area. She then did private practice in Jersey City, and became interested in pediatrics and epidemiology. She served as a Health Officer, and eventually became medical director of the Isolation Hospital. Dr. Rundlett was a pioneer in the development of equipment for treating poliomyelitis. She was appointed to the faculty of the Seton Hall College of Medicine and Dentistry. Seton Hall University in 1956 awarded her an honorary degree of Doctor of Laws. Hudson County newspapers describe Dr. Rundlett as "The Dean of Polio Fighters." Dr. Rundlett was a Fellow of the American College of Physicians.

DR. ABRAHAM SHULMAN

A past-president of the Passaic County Medical Society, Dr. Abraham Shulman died on November 22, 1959. Born in Pennsylvania in 1896, his family moved to Paterson in 1911. In 1918 he was graduated from the medical school of New York University. After a period of general practice, he became increasingly interested in obstetrics and gynecology, eventually becoming chief of that service at the Barnert Hospital. He was a diplomate in obstetrics and gynecology and served a term as president of our state Obstetrical Society. He was one of the founders of the American Academy of Obstetrics and Gynecology, and a director of the Home for the Aged in Clifton. He was interested in public education and was a popular writer of sound medical articles for the lay press. Dr. Shulman served as moderator of a public forum on obstetrics on several occasions. Only 64 at the time of his death, he had served the people of Passaic and Bergen Counties for over 40 years.

Supplementary List No. 2

to the

1959-60 Membership Directory

Memberships reported from September 11, 1959 through December 10, 1959

N—New
R—Reinstated

	Name	Address	County	Practice
		ACTIVE MEMBERS		
R	Butler, Samuel S.	1208 Mt. Ephraim Ave., Camden	Camden	General
R	Casselman, Arthur J.	301 N. Second St., Camden	Camden	General
R	Cerchio, Michael P.	479 Jersey Ave., Jersey City	Hudson	General
N	Cogger, William A.	16 Johnston Dr., Watchung	Union	General
N	Console, A. Dale	Carson Rd., RD. #3, Princeton	Mercer	Psy
R	Dempsey, J. Harvey	66 Washington Ave., Berlin	Camden	General
R	Eck, John H.	117 S. Fullerton Ave., Montclair	Essex	General
R	Ferri, C. Joseph	523 Roseville Ave., Newark	Essex	Surg
R	Finger, Frederick A.	943 Avenue C, Bayonne	Hudson	——
N	Freas, Howard M.	47 Blackburne Terr., West Orange	Essex	——
R	Haines, Mabel S.	600 White Horse Pike, Audubon	Camden	General
N	Innerfield, Irving	20 Knickerbocker Rd., Tenafly	Bergen	——
N	Randle, Roscoe P.	N. J. State Dept of Health, 129 E. Hanover St., Trenton	Mercer	Govt
R	Kaplan, Benjamin B.	1815 Hudson Blvd., Jersey City	Hudson	——
R	Levitov, Leo	246 Union St., Jersey City	Hudson	General
R	Makarenko, Valentina	18-75th St., North Bergen	Hudson	Gen, Anes
R	Massey, John B.	665 High St., Newark	Essex	Gen, Pul TB
R	Moss, Jack W.	476 Wyckoff Ave., Wyckoff	Bergen	——
N	Nargiello, Eugene	John E. Runnells Hosp., Scotch Plains	Union	——
R	O'Connor, Paul A.	342 Roseville Ave., Newark	Essex	Surg
N	Papperman, Sol M.	32 Main St., Lodi	Bergen	Int Med, GE
N	Proctor, Robert G.	Medical Arts Bldg., Princeton	Mercer	Ob, Gyn
R	Rhone, David S.	19 Kings Hwy., E., Mt. Ephraim	Camden	——
R	Rock, Donald E.	627 Bogert Road, River Edge	Bergen	Ob, Gyn
R	Rogers, Alan S.	434 Washington Ave., Haddonfield	Camden	General
N	Roth, Daniel	Bergen Pines Hosp., Paramus	Bergen	Path
N	Salzman, Morris	77 Union St., Dover	Morris	Ob, Gyn
R	Shaw, Ernest B.	811 Collings Ave., West Collingswood	Camden	General
R	Sinclair, Paul F.	570 Bramhall Ave., Jersey City	Hudson	General
R	Tornow, Abraham M.	37 Bentley Ave., Jersey City	Hudson	Diabet
N	Winston, John S.	675 Broadway, Paterson	Passaic	Ped
		ASSOCIATE MEMBERS		
	Alloway, Clifford J.	609 Greenwood Ave., Trenton	Mercer	General
	Ambrose, Robert B.	529 Ridge St., Newark	Essex	Resident
	Barrett, John F.	400 Center Ave., Westwood	Bergen	——
	Bernstein, Michael	206 Millburn Ave., Millburn	Essex	——
	Bernstein, Mitchel	620 Newark-Pompton Tnpk., Pompton Plains	Passaic	——
	Bromley, John W.	310 Broadway, Paterson	Passaic	Orth Surg
	Campbell, John M.	528 Broadway, Paterson	Passaic	Ob, Gyn

Cerfolio, Robert D.	117 E. 21st St., Paterson	Passaic	Urol
Christie, Alfred D.	1451 W. State St., Trenton	Mercer	——
Chutkow, Lee R.	49 S. Munn Ave., East Orange	Essex	Neur-Psy
Dalglish, Lawrence	55 Plymouth St., Montclair	Essex	General
DiLiberti, Charles	188 S. Essex Ave., Orange	Essex	Rad
Dwyer, William A., Jr.	99 Park Ave., Paterson	Passaic	Gen Surg
Epstein, Howard N.	2786 Princeton Pike, Trenton	Mercer	General
Evans, Thomas L.	Medical Arts Bldg., Princeton	Mercer	
Finkel, Jerrold S.	1036 Amboy Ave., Fords	Middlesex	Ob, Gyn
Fladd, Coralyn R.	E. R. Squibb & Sons, Georges Rd., New Brunswick	Middlesex	Ind
Gersten, Hilliard C.	Oceanport Ave., Oceanport	Monmouth	General
Hakim, Houshang	320 Asbury Ave., Asbury Park	Monmouth	——
Hartert, Dietrich	N. J. Neuro-Psychiatric Inst., Box 1000, Princeton	Mercer	Psy
Hausheer, Bernhardt W.	622 E. Palisade Ave., Englewood Cliffs	Bergen	Ped
Hersh, Norman S.	806 Valley Rd., Wayne	Passaic	Ped
Jacoby, Arthur W.	250 Kinderkamack Rd., Westwood	Bergen	Orth Surg
Jasper, Philip J.	80 Howe Ave., Passaic	Passaic	——
Kostrzewa, Raymond M.	980 S. Broad St., Trenton	Mercer	General
Lagomarsino, Fred J.	104 Congress St., Newark	Essex	General
Layman, William A.	208 Anderson St., Hackensack	Bergen	Teach
Madiou, Roger J.	812 Hamilton St., New Brunswick	Middlesex	General
Masley, Peter	57 Notch Rd., Clifton	Passaic	——
Molchan, Alexander E.	3 Cathedral Ave., Nutley	Essex	Int Med, Card
Mondini, Giulio	725 Palisade Ave., Cliffside Park	Bergen	——
Nazzaro, Genuino	5 Stanworth Rd., Franklin Park	Mercer	General
Nichols, Reuben, Jr.	641 Hunterdon St., Newark	Essex	——
Oropollo, Anthony T.	8 Mt. Pleasant Pl., W. Orange	Essex	——
Pear, Edwin J.	701 Valley Rd., Wayne	Passaic	Ob, Gyn
Pesaresi, Mario L.	208 Anderson St., Hackensack	Bergen	Child, Gen Psy
Pesin, Arthur D.	1580 Lemoine Ave., Fort Lee	Bergen	Ped
Rado, Richard W.	24 High St., Butler	Passaic	Gen Surg
Reed, Richard C.	161 Roseville Ave., Newark	Essex	——
Reisfield, Donald R.	96 Jefferson Rd., Princeton	Mercer	——
Rorro, Mary A.	295 Hamilton Ave., Trenton	Mercer	General
Schachtel, Norman H.	393 Northfield Dr., West Orange	Essex	——
Siegler, Richard	Rocky Hill	Mercer	——
Staniszewski, Herbert	75 Totowa Ave., Paterson	Passaic	Anes
Tinterov, Ludmil A.	31 Lincoln Pk., Newark	Essex	Otolar
Tzibrouk, Leonid	257 Fair St., Paterson	Passaic	——
Weisberg, Jerry	272 Saddle River Rd., Saddle Brook	Bergen	General
Williams, Thomas M.	130 Brunswick Ave., Trenton	Mercer	——

Civil Defense Items • • •

Fifty 200 bed Emergency Hospitals are already stationed in New Jersey. The total allocated to New Jersey, if space for storage can be found is 82.

MATCHING FUND PROGRAM—OCDM

The 1960 *Federal Contribution Manual,* AM-25-1, has been forwarded to county and municipal civil defense directors. Physicians with civil defense responsibilities should examine the chapters on Training and on Health Services and send recommendations to their civil defense director before May 2, 1960. Other chapters should be examined for pertinent related items such as generators, chlorinators, and so on.

Items need not be purchased and paid for before May 2, 1960 but the "application" should be submitted and approved before then since all monies in the Federal Contribution Budget are cut off as of June 30, 1960. The county and municipal civil defense organizations have a two-year period for claiming reimbursement if their application is received and approved prior to May 1960.

Physicians should make certain that their civil defense organization is ordering adequate supplies for first aid, hospitals, blood banks, radiologic-chemical services, and environmental sanitation. Consideration should be given to personnel protective devices such as gas masks, helmets, and atropin syrettes.

Assistance can be obtained from the Office of Civil Defense Medical Services, State Health Department in Trenton. Telephone EXport 2-2131, extension 8494.

SURPLUS PROPERTY AND CIVIL DEFENSE

The Government has made available $130,000,000 worth of surplus property to the States in the last quarter of 1959 to be distributed among educational, public health, and civil defense institutions. Our State, in the last two years, has received $2,000,000 worth of original government acquisitional cost. More than half has been made available to civil defense organizations of 200 municipalities within New Jersey.

COUNTY CIVIL DEFENSE TRAINING CENTERS

Essex County and the State are initiating a joint training program for First Aid and for the 200 bed Emergency Hospital Unit now at the Essex County Overbrook Hospital, Cedar Grove.

Sussex County has appropriated $65,000 for an installation to be used as a multi-program training center, as well as a sheltered control center.

MANAGEMENT OF MASS CASUALTIES

The Army has made available spaces for two civilian physicians for each of their scheduled courses. The courses are offered at Fort Sam Houston, San Antonio, Texas, February 15 to 19, 1960; April 25 to April 29, 1960, and June 13 to June 17, 1960. Physicians interested in attending should write to the Council on National Defense, American Medical Association, Chicago.

QUOTE TO NOTE:

"This country has had problems before, and it has always managed to cope with them, once it gained the understanding and support of its citizens. Still, none of the dangers we have faced in the past can compare to the formidable threat of nuclear aggression which we are facing today. Nor will we ever again have the time to plan, to rally, and to act after the aggressor has struck. If he were to strike today, he would find us ready to strike back but ill prepared to ward off his blow." General Thomas S. Power, Commander, Strategic Air Command, in Army-Navy-Air Force *Register and Defense Times,* September 19, 1959.

Announcements • • •

Pediatric Oncology

Announcement is made of a course in pediatric oncology to be given in New York City at the Memorial Center, April 27, 28 and 29, 1960. Tuition is $35. The program includes rounds, seminars, examinations, colloquia, demonstrations, slide presentations and so on. For details, write to Pediatric Service, Memorial Center, 444 East 68 Street, New York 21, New York.

Research and Psychotherapy

On March 23, 1960, the Association for the Advancement of Psychoanalysis will sponsor a lecture by Dr. David M. Rioch on "Research Contributions to Psychotherapy." This is the annual Karen Horney memorial lecture. Dr. Rioch is director of psychiatry at the Walter Reed Institute of Research in Washington. The presentation begins promptly at 8:30 p.m. at the Academy of Medicine, 4 East 103 Street, New York. There is no fee.

Obstetrics-Gynecology Examinations

The American Board of Obstetrics and Gynecology will conduct examinations in Chicago April 11 through April 16. For more details, write to Dr. Robert Faulkner, 2105 Adelbert Road, Cleveland 6, Ohio.

Are Your Patients Going Abroad This Summer?

The Public Health Service has issued a new edition of its brochure on immunization requirements for Americans going abroad. The booklet sells at a modest 30 cents a copy and is obtained from the Government Printing Office, Washington 25, D. C. Ask for "Immunization Information for International Travel." Some physicians like to present copies of this useful booklet as going-away gifts to their travelling patients. If so, the book is available at quantity discounts.

Poison Control Centers

If you don't bind your JOURNALS, cut out this list and keep it on your desk top. Or make a special note of the poison control centers near you. These centers provide 24-hour service. They can tell you the active ingredient in a household poison or suggest an antidote. They are prepared to treat persons brought directly there.

City	Telephone
Asbury Park—Fitkin Hospital	Prospect 5-5500
Atlantic City—A. C. Hospital	Atlantic City 5-2112
Belleville—Clara Maass Hospital	Plymouth 1-1000
Camden—West Jersey Hospital	Woodlawn 3-8830
Elizabeth—St. Elizabeth's Hosp.	Elizabeth 5-3100
Flemington—Hunterdon Med. Cen.	Flemington 850
Long Branch—Monmouth Med. Cen.	Capital 2-5200
Montclair—Mountainside Hosp.	PIlgrim 6-6000
Morristown—Memorial Hospital	Jefferson 8-4500
Morristown—All Souls Hospital	Jefferson 8-0900
New Brunswick—St. Peters Hospital	Kilmer 5-8000
New Brunswick—Middlesex Hosp.	Kilmer 5-8200
Newark—Babies Hospital	Humboldt 2-6200
Newark—Clara Maass Hosp.	Plymouth 1-1000
Newark—Beth Israel Hosp.	Waverly 3-6000
Neptune—Fitkin Hospital	Prospect 5-5500
Newton—Memorial Hospital	Newton 580
Nutley—Child Safety Center	North 2-0139
Orange—Memorial Hospital	Orange 5-1100
Paterson—General Hospital	Mulberry 4-6900
Phillipsburg—Warren Hosp.	Phillipsburg 5-1131
Perth Amboy—General Hosp.	Hillcrest 2-3700
Princeton—Princeton Hospital	Walnut 1-7700
Summit—Overlook Hospital	Crestview 3-8100
Teaneck—Holy Name Hospital	Teaneck 7-3070
Trenton—Helene Fuld Hospital*	Owen 5-5491

*The Helene Fuld Hospital used to be called the McKinley Hospital.

Chest Disease Symposium

The American College of Chest Physicians presents a graduate course on diseases of the chest at the Sheraton Hotel in Philadelphia, March 14-18. The most recent advances in the diagnosis and treatment of heart and lung diseases, medical and surgical aspects, will be reviewed. Tuition for this five-day course is $100, including round table luncheon discussions. For further information, write to Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Clinical Physiology Course

New York University offers a course in clinical physiology on Thursdays, 7:30-9:30 p.m., March 3 through April 21. This summarizes the latest concepts of the physiology of the heart, vessels, kidneys, lungs, liver, endocrine glands and body fluids.

Clinical disorders are discussed as evidence of inability to reach the functional capacity necessary to perform the physiologic task. Emphasis is placed on principles of metabolism including body fluid and electrolyte metabolism. Fluid and electrolyte problems and metabolic disturbances are investigated. This course is under the direction of Dr. Norman Deane.

For additional information, write to: Associate Dean, Graduate Medical School, 550 First Avenue, New York 16, N. Y.

Riverside Hospital Accredited

The Joint Commission announces the accreditation of Riverside Hospital in Boonton, N. J. after only four years of operation. Riverside is the only hospital in Boonton, and is now a 65-bed institution, engaged in a campaign to add a new wing. Dr. Charles H. Deichman is the medical director.

Essay Award: Bed Sores

The American Congress of Physical Medicine and Rehabilitation announces the R. D. Grant Company essay contest. Subject: Etiology of Decubitus Ulcers. Deadline is May 1, 1960. Contributions must not exceed 6000 words. Winner will receive $1000. For details, write to American Congress of Physical Medicine at 30 North Michigan Avenue, Chicago 2, Illinois.

Don't Use Test Papers to Determine Fertility

The use of certain chemically treated diabetes test papers by women to determine the fertility cycle should be discontinued immediately, the Food and Drug Administration warns. Some of these papers contain tolidine, which may adversely affect the sensitive tissues of the internal genitalia. The papers are marketed for use by diabetics, who are able to detect sugar in the urine by moistening the paper with a small amount of urine. This is a perfectly safe procedure.

The secretions of the cervix contain enough sugar during the ovulation period to cause this test paper to change color. This has led some women to use the test papers for determining the fertile period of the menstrual cycle. There is also available a plastic device for applying the papers to the cervix. While the manufacturer does not recommend the tolidine-treated test papers, FDA is concerned lest women who already have a supply on hand may continue to use them.

The product specifically aimed at in the FDA warning bears the trade name of "Tes-Tape" and is marketed by Eli Lilly and Company for use *only* by diabetics. Lilly has *not* recommended its product for testing fertility.

The Family Role of the Nurse

During the week of February 15, Rutgers University will hold a colloquium on the role of the nurse in support of the family during hospitalization of the child. Topics to be covered include the use of play activities to facilitate recovery of the child; the child's "image" of himself when sick; the preparation of parents for the hospitalization of the child; and the use of puppets and other play to highlight the role of the nurse in the child-parent-nurse triad. For further details write to Professor of Nursing, Rutgers University, 40 Rector Street, Newark.

County Society Reports • • •

Atlantic

The regular meeting of the *Medical Society of Atlantic County* was called to order by President Louis Rosenberg on November 13, 1959 at the Children's Seashore House.

Dr. Harvey Vandegrift introduced the speaker for the evening, Dr. Lewis L. Coriell, Director of South Jersey Medical Research Foundation. His topic was "Viruses—Current Concepts of Diagnosis and Treatment." His complete and informative talk was discussed by Dr. Milton Ackerman.

Dr. Peter Marvel, reporting for the Board of Censors, recommended the admission to Courtesy membership of S. David Freedman, D.D.S.; to Regular membership, Dr. Frank Perry; and to Associate membership, Dr. Fredrick Panico and Dr. George J. McKeon.

Dr. Max Gross reported for the Public Health Committee. He did a great deal of work preparing a resolution regarding Eastern Equine Encephalitis, which was adopted by the Society. Their work was referred to Dr. Robison Harley to be used at the discretion of the Public Relations Committee. A copy of the resolution will also be sent to Governor Meyner, to our Senator, to representatives of surrounding counties, to the District Health Officer for Southern New Jersey, and to Dr. Roscoe P. Kandle, Health Commissioner for New Jersey.

Dr. Harold Davidson has been appointed as our representative to the Senior Citizens Committee. This increasing group requires assistance from our community. The commissioners of Atlantic City have established Day Centers for them. Dr. Rosenberg feels that our Society should help in all ways to develop this program, and it was suggested that Dr. David B. Allman be approached on this problem and that we have him as one of our speakers.

The meeting was adjourned for the usual light repast.

LEONARD B. ERBER, M.D.
Reporter

Bergen

The regular meeting of the *Bergen County Medical Society* held December 8, 1959, at Bergen Pines, Paramus, was called to order by Donald B. Hull, M.D., president, at 9:00 p.m. There were 175 members and guests present.

Minutes of the meeting of November 10, and those of the Executive Committee of November 17, were, on motion, accepted as printed in the December *Bulletin*.

The Executive Secretary introduced the following Associate members who had been elected in November: Drs. Anna Herman, Robert G. Kerdasha, and Guillermo J. Munoz.

The Executive Secretary read the following names, which had been approved by the Executive Committee for election to membership:

To Regular by transfer—Bradley D. Berry (from Buchanan Dickenson Med. So.—Va.), W. Kenneth Clark (from Dauphin Co. Med. Soc.—Pa.), Joseph J. Geller (from Passaic Co. Med. Soc.); To Associate—Marvin M. Siegler.

It was moved, seconded and carried that the Secretary be instructed to cast one ballot for the election of this panel.

The Chair turned the meeting over to Dr. Bertha P. Rodger, of the Program Committee. Dr. Rodger called attention to recent interest in hypnosis in the practice of medicine and presented Dr. Milton H. Erickson, President of the American Society of Clinical Hypnosis and Editor of its journal. Dr. Erickson spoke on "Hypnosis in General Practice." He illustrated his presentation with four subjects, three of whom had no previous experience in hypnosis. After a lengthy and spirited question and answer period, the chair expressed the appreciation of the membership to Dr. Erickson for his illuminating lecture.

There being no further business to come before the meeting, it was adjourned to collation at 11 p.m.

CHARLES P. CAMPBELL, M.D.
Reporter

Burlington

The *Burlington County Medical Society* met on November 12, 1959 at Millside Farms Dairy Bar with President Haldeman in the chair. The program, presented by Dr. Carl Maxwell, consultant in Orthopedic Surgery at Kessler Institute, concerned itself with "Rehabilitation in Medicine." Assisting him were Mr. John Ellis and Dr. Bloom of the State Rehabilitation Commission. We thus were given a fruitful, informative discussion about the type of help available, the group of patients who would be eligible, and the mechanics of securing this aid. Most of us were previously ignorant of this field and we should now be able to assist some of our patients far more effectively; and conversely the State Commission more completely understands some of our problems.

Dr. E. Vernon Davis, Chairman of the Committee on Interprofessional Relations with the Burlington County Bar Association, reported that his committee unanimously endorsed the code of ethics approved by The Medical Society of New Jersey and State Bar Association. Our Society went on record as approving.

The Society had discussed in the past the propriety of new physicians in an all new community (specifically Levittown, N. J.) inserting a paid notice in the local paper of the establishment of their office, type of practice and office hours. Because of the special circumstances in establishing a practice in such a community, a heavy majority of the members felt that such a notice, as described and recommended by the State Society Board of Censors, was in fact, ethical and should be allowed.

Dr. Robert Gelber, Pemberton, was voted into Associate membership.

LINDLEY B. REAGAN, M.D.

Reporter

Cumberland

The December meeting of the *Cumberland County Medical Society* was held Tuesday, December 8, 1959, 2:30 p.m., at Richards Farm, Rainbow Lake, with Benjamin Berkowitz, M.D., of Bridgeton, presiding.

The following Associate members were approved by the Society for advancement to Active membership: Drs. Joseph A. Bonaccorsi, Anthony F. Napoli, Walter Pavlin, and Ahmet Samedov of Vineland; Charles E. Eby, Gerald Eichner, and Alfred G. Elmer of Bridgeton.

Dr. Nicholas E. Marchione, of Vineland, informed the Society that the New Jersey Chapter of the American Academy of General Practice will present its 8th Annual Session, January 9, at Atlantic City.

The amendments suggested by the Constitution and By-Laws Committee comprising Drs. Samuel B. Pole, III, Chairman, Nicholas E. Marchione and Carl Ware, were formally adopted.

Dr. Ralph Phillip of Bridgeton, chairman of the Annual Diabetes Detection Drive, gave a provisional report.

Dr. Carl Ware, of Shiloh, was unanimously proposed for the office of Second Vice-President of The Medical Society of New Jersey because of his wealth of experience, his position of palatial esteem among his colleagues and his exemplification of devotion to service.

Dr. Leonard G. Scott, of Bridgeton, chairman of the Public Relations Committee, reported on the Council on Public Relations, which met in Trenton on October 18, 1959.

A resolution was adopted and sent to the family of the late George Norfleet Thomas, M.D., of Vineland.

The guest speaker was Newlin F. Paxson, M.D., Professor of Obstetrics and Gynecology at Hahnemann Medical School and Hospital, Philadelphia. His subject was "Lesions of the Cervix." Dr. Paxson gave an informative lecture on the classification, the treatment and the prognosis of the diseases of the cervix and demonstrated his points with lantern slides. A lively question and answer period followed his presentation.

The meeting then adjourned for dinner.

LEONARD G. SCOTT, M.D.

Reporter

Hudson

The regular meeting of the *Hudson County Medical Society* was held at Jersey City Medical Center on December 1, 1959. Dr. Charles E. Rosen presided. Guest speaker of the evening was Mr. William Sussman, Research Specialist of Sutro Brothers, who presented a very interesting discussion on investment clubs.

A report was given by Dr. Sidney Woltz regarding the Diabetes Detection Drive.

The following were elected to membership: Drs. Louis G. Bosco and Duncan E. Hutcheon of Jersey City, Gilbert Levinson of Bayonne and Harvey S. Moser of New York City.

Following the business meeting a collation was served.

ROY A. MORROW, M.D.

Reporter

Mercer

Mr. George E. Stringfellow, Vice-President, Thomas A. Edison Industries of the McGraw-Edison Company, was the guest speaker at the annual banquet of the *Mercer County Component Medical Society*, held at the Trenton Country Club, December 9, 1959.

Dr. Samuel J. Lloyd, immediate past President (1958-1959) was the recipient of a testimonial in appreciation of the services rendered the society during his administration.

The following physicians were elected to membership during a brief business session: Active—Keith G. Battin (on transfer from Shawnee County (Kansas) Medical Society; A. Dale Console (on transfer from The Medical Society of the County of New York), and Eugene Hrabarchuk; Associate—John J. Shea.

R. N. CAGAN, M.D.

Reporter

Middlesex

The November meeting of the *Middlesex County Medical Society,* under the chairmanship of Dr. John A. Smith, President, was held at the Roosevelt Hospital in Metuchen, at 9:00 p.m. on Nov. 19, 1959.

Upon recommendation of the Judicial-Medical Ethics Committee, the following were elected to regular membership from two years' associate membership: Doctors William Dawson, Metuchen; Leon Silverman, New Brunswick, and Leonard M. Hirsch, Perth Amboy. Dr. Martin B. Stahl was accepted for regular membership by transfer from New York. Elected to two years' associate membership were Dr. Jerrold B. Finkel, Edison Township, and Dr. Joseph Pilecki, South River.

Dr. Stanley Gadek introduced a resolution requesting the Board of Freeholders to increase the allowance for indigent patient hospital care in voluntary general hospitals of Middlesex County to the state authorized limit of $600,000. The resolution was passed.

Mr. James Zotti of the New Jersey Medical-Surgical Plan, reviewed the "Present Medical-Surgical Plan." The new riders for the basic plan were discussed with detailed questioning from the audience. Society members are now eligible to purchase the new riders.

Final changes in the Constitution and By-Laws were made. They will now be re-printed and sent to the membership.

THOMAS I. STEINBERG, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on November 17, 1959 at 9:00 p.m. at the Valley View Hospital. Dr. Julian Cohen, the president, called the meeting to order and introduced Dr. Missonellie, President of the Board of Managers of Valley View, who welcomed the members.

The following were elected to Associate membership: Drs. Robert Dunkelman of Bloomingdale and N. Frank Riccioli of Clifton.

A resolution on the death of Dr. Anthony C. Ciccone was adopted as read.

Dr. Jehl, Chairman of the Insurance Committee, was called upon to report on a major insurance plan for Society members. Most members felt that they would be interested in this type of coverage but requested more specific details.

Dr. Jehl also spoke on the Homemaker Service and requested the members to enlist as supporting patrons with a contribution to help maintain this worthwhile project.

The meeting was then turned over to Dr. Cherry, Medical Director of the Valley View Hospital, who presented a case of pulmonary tuberculosis in which ACTH and cortisone gave excellent results despite the fact that this is not the generally recognized treatment.

Dr. Bradley, Chief Resident Physician, presented two cases of mumps complicated by encephalitis which had responded to steroid treatment. This stimulated a lively discussion on the use of steroids in general and in relation to the cases presented in particular.

IRVING CHRISMAN, M.D.

Reporter

COUNTY SOCIETY PRESIDENTS AND SECRETARIES

County	President	Secretary
Atlantic	Louis Rosenberg, Atlantic City	John W. Holland, Atlantic City
Bergen	Donald B. Hull, Ridgewood	Charles P. Campbell, Hackensack
Burlington	Robert E. Haldeman, Mount Holly	R. Winfield Betts, Medford
Camden	Vincent T. McDermott, Camden	James G. Dickensheets, Camden
Cape May	Robert G. Stineman, Cape May Court House	Ulric J. Laquer, Cape May Court Hse.
Cumberland	Benjamin Berkowitz, Bridgeton	Mary Bacon, Bridgeton
Essex	John J. Torppey, East Orange	R. E. Remondelli, East Orange
Gloucester	Dorothy M. Rogers, Woodbury	Francis M. Brower, Woodbury
Hudson	Charles E. Rosen, Union City	Matthew E. Boylan, Jersey City
Hunterdon	Leonard Rosenfeld, Ringoes	John B. Fuhrmann, Flemington
Mercer	John A. Kinczel, Trenton	Ralph N. Cagan, Trenton
Middlesex	John A. Smith, South River	John S. Van Mater, New Brunswick
Monmouth	Lester A. Barnett, Long Branch	William J. D'Elia, Spring Lake
Morris	Augustus L. Baker, Jr., Dover	Dexter B. Blake, Far Hills
Ocean	J. Bruce Henriksen, Point Pleasant	Jesse Schulman, Lakewood
Passaic	Julian Cohen, Paterson	Joseph E. Mott, Paterson
Somerset	George A. Nitsche, Jr., Monroeville	William L. Sprout, Salem
Sussex	Robert R. Ambrose, Bound Brook	Howard Adler, Somerville
Salem	Victor E. Burn, Newton	Edward K. Hawke, Newton
Union	Nathan S. Deutsch, Elizabeth	Elbert H. Pogue, Elizabeth
Warren	Raymond Cooper, Washington	Ralph M. L. Buchanan, Phillipsburg

Book Reviews • • •

Textbook of Surgery. Edited by H. F. Moseley, M.D. St. Louis 1959, Mosby. Ed. 3. Pp. 1336. ($17.00)

In 1952 this book, written largely by Canadian surgeons, was first offered to the practitioners. It rapidly became one of the most popular one-volume surgeries available. This edition, like its two predecessors includes material on the history of surgery, on bacteriology, chemotherapy, pathology, anesthesia, radio-isotopes, shock and blood transfusion in addition to chapters covering the surgery of each part of the body. There is good coverage of symptomatology, choice of treatment (non-surgical methods are honestly evaluated), surgical technic and differential diagnosis. The drawings (many of them by Netter) are clear, the writing is fluent, and the material is practical. The chapter on cardiac surgery has been greatly enlarged over the material in the second (1955) edition. There is a new chapter on pediatric surgery. This is a satisfying and satisfactory volume.

ULYSSES FRANK, M.D.

Current Therapy: 1959. Edited by Howard F. Conn, M.D. Philadelphia 1959. Saunders. Pp. 781. ($12.00)

In the practice of medicine, treatment is the pay-off. Everything else—pathology, etiology, diagnosis—is important only as it contributes to treatment. The hurried and harried practitioner often complains that standard texts are padded with histologic descriptions, epidemiologic comment or diagnostic theory. If this is your complaint, look no further. Here is your meat. A king-sized volume devoted to treatment. The text is personalized in that the treatment program for each condition is described as the "Method of—" naming the responsible expert. Monographs cover the infectious diseases from amebiasis to whooping cough; the respiratory system from atelectasis to tuberculosis—and so on through cardiovascular, hematologic, gastro-intestinal, and metabolic disorders; and on through the specialties: dermatology, obstetrics, neurology, trauma and so on.

Special features include an extensive table of pediatric posology, a good section on poisons, and endpapers which display normal laboratory values. Especially useful is a section on drugs giving packaging and dosage information.

The print is large, clean and readable. The text is solid, the pace and style of writing are excellent. Altogether a big, handy desk book well worth the space it takes.

FELIX A. UCKO, M.D.

Synopsis of Surgery. Originally by E. W. H. Groves, M.D. This 15th edition by Sir Cecil Wakeley. Baltimore 1959. Williams and Wilkins. Pp. 650. ($8.50)

Groves has been serving medical students, interns and practitioners since 1908. This is the fifteenth edition. In view of the massive acceptance of this compact *vade mecum*, there is not much point in a long book review. The medical public has already given its verdict. It includes new material on vascular surgery and antibiotics. Like its predecessors, it follows the "outline" form so popular among British medical students. It is illustrated with 13 plates and 190 line drawings. The text covers inflammation, suppuration, gangrene, and injuries and diseases of every region of the body. A wonderful quick-reference book, it will earn its keep on any doctor's desk or shelf.

VICTOR HUBERMAN, M.D.

Changing Concepts and Practices in Occupational Therapy. Wilma L. West, M.A., O.T.R. New York: The American Occupational Therapy Association, 1959. Pp. 248. ($1.50)

This is essentially a recording of the Conference on the Psychiatric Occupational Therapist, held in November of 1956. In addition to recording the project, the editor has injected many interesting views, both her own, and those of other authorities.

The keynote address by Dr. Elvin V. Semrad and Dr. Max Day, makes for most interesting and informative reading. Titled "Technics and Procedures in the Treatment and Activity for Psychiatric Patients," it forms a fitting and pertinent introduction to the material which follows.

The book concerns itself with technics and activities used in psychiatric occupational therapy and the role of the occupational therapist in relationship to other specialists in psychiatric activity programs. Also discussed are current and future trends in psychiatric occupational therapy. Attention is paid to educational and practical preparation of occupational therapists and their needs for the future.

One of the prime purposes of this book is to offer a definition of the role of the occupational therapist, his relationship to other activity specialists, and from this definition, to formulate the training necessary to this end. In the process of this introspection, the author has provided an excellent handbook for all workers in the psychiatric field. I think that the book should be a part of every medical library. It is a welcome addition in a field where there has been for years a dearth of definitive literature.

CLIVE KRYGAR, JR., O.T.R.

Practical Dermatology. By George M. Lewis, M.D. Philadelphia, 1959. Saunders. Pp. 363 with 555 illustrations. ($8.00)

This second edition was undertaken to keep abreast of the rapid changes in dermatologic knowledge, and to lay added stress on the basic sciences as they relate to dermatology. Dr. Lewis states in the preface, that an author should consider himself fortunate, when he has the opportunity to rewrite his text after a period of reflection. The author's reflections were fruitful indeed, because the book is excellent.

The old German concept of dermatology (*Ausere Medizin*) as a thing apart from internal medicine (*Innere Medizin*), is laid to rest in this book. It is refreshing, and an important step forward to see the skin dealt with as another important organ of the total organism.

This text is necessarily brief, since it is written for the medical student and general practitioner. As one of Dr. Lewis' students, I regret that the brevity cannot do justice to the kind, gentle, inspiring and patient teaching methods of this author. His ability to make a difficult subject easily understood is as clearly expressed in this volume, as in his earlier "Introduction to Medical Mycology."

JACOB BLEIBERG, M.D.

Your Mind Can Make You Sick or Well. By C. S. Wachtel, M.D. New York 1959, Prentice-Hall. Pp. 244 with a life-chart. ($4.95)

A mother, it says here, "found herself on the brink of tuberculosis, but was able to avert tragedy through Dr. Wachtel's help." (How can you be on the *brink* of tuberculosis?). A housewife's "itching eczema sent her to Dr. Wachtel for advice. Under his supervision, the eczema cleared up completely." Not only that, but it also says here that "Dr. Wachtel equips you with a unique 'Life-Chart' that holds up a magic mirror to your years."

All this for $4.95.

ABRAHAM LEFF, M.D.

Morbidity from Cancer in the United States. Public Health Service Publication Number 590. Washington, D. C., 1959. Government Printing Office. $1.00)

Among the findings reported in this monograph are that the incidence of a number of specific forms of cancer may be associated with socio-economic status.

The most consistent relationship observed is a relatively high incidence rate for cancer of the upper alimentary tract, pancreas, respiratory system, and uterine cervix *among the lowest one-third income group* in each community studied. Further evaluation of such relationships will be needed to discover etiologic factors responsible for the apparent variations in incidence in different population groups.

The authors of the work are Dr. Harold F. Dorn, National Institutes of Health, and Sidney J. Cutler, National Cancer Institute. Part I of the monograph, which was published separately in 1955, deals with variations in the incidence of cancer by age, sex, race, marital status, and geographic region. The current publication completes the 10-city analysis and combines the analysis contained in part I with that in part II, which deals with inter-city variation in cancer incidence and income class, and stage of disease at diagnosis.

The study represents a statistical analysis of thousands of cancer cases examined in 10 large population centers in the United States which were surveyed in 1937-39 and resurveyed 10 years later.

HENRY A. DAVIDSON, M.D.

A History of Neurology. By Walter Riese, M.D. New York 1959, M.D. Publications, Inc. Pp. 223. ($4.00)

After getting off to an interesting opening, this book suddenly collapses and ends up with two almost empty chapters. One, called "History of Prognosis in Neurology" has no meat in it at all. The other, "History of Therapy in Neurology" tells very little about the history of therapy in neurology. The book is printed on pulpy paper. Its readability is somewhat impaired by the author's enchantment with Latin phrases, incomprehensible to most of us.

The book includes an account of the historical development of basic concepts in neurology and reflex actions. There are indices of names and of subjects. There is also a list of neurologic societies and neurologic publications. Finally there is an interesting "neurologic chronology" in tabular form which relates people, achievements in neurology, and major events in world history.

HERBERT BOEHM, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

JANUARY 1960 • VOL. XXXII, No. 1

THE NATURAL HISTORY OF EMPHYSEMA IN MAN

The clinical course of typical diffuse emphysema is described. Patients with a less typical clinical picture and closely related clinical entities are also discussed.

In describing the natural history of a disease we must first establish a definition. To do this, we classified a group of patients into a category on the basis of one or more common characteristics. Once this is done, the clinical symptoms and course of the disease can be described.

DEFINING EMPHYSEMA

The problem in emphysema lies in the area of definition of the disease and hence classification of patients. If the records of any hospital are scanned, it will be found that the term emphysema is often loosely used and applied to a diversity of clinical problems. Hence, to give any coherent account of the clinical course of the disease, we must establish a rigid definition. The traditional method of classification of emphysema is based on clinical-pathological correlation. This method has severe limitations. The pathology of emphysema is not an all or none phenomenon. One can state with some assurance that a patient has or has not bronchogenic carcinoma or pulmonary tuberculosis. In the case of emphysema the degree of change in the lung may range from a few bullae or dilated air spaces to a condition in which both lungs may be almost entirely replaced by bullae. In emphysema the pathology must be defined quantitatively as well as qualitatively.

There are other problems related to the pathologic definition of emphysema. Most pathologists do not fix the lungs in an inflated state. Hence, the gross and microscopic evaluation of the disease lacks precision. The pathologic process is not accurately reflected in the roentgenogram and we must await the death of the patient for an accurate appraisal of the changes in the lung.

For these reasons clinicians have begun to rely more and more on a physiologic definition of emphysema. Unfortunately, the data are not available to correlate precisely this physiologic definition of the disease with the pathologic definition.

CLINICAL COURSE

A description of the clinical course of patients with typical diffuse hypertrophic or obstructive emphysema, in essence, differs little from the original description of Laennec. There are patients, however, who present a less typical clinical picture.

The chief symptom of emphysema is dyspnea beginning as exertional dyspnea. The patient notes that his activity is being limited progressively because of shortness of breath. Often this limitation of activity is attributed to aging or loss of physical fitness. Finally the patient is unable to walk even a short distance without being tortured by dyspnea. Episodes of dyspnea occur at rest and are accompanied by wheezing. These acute episodes, often referred to as "asthma," are usually precipitated by an upper respiratory infection. Administration of adequate amounts of antimicrobial drugs usually gives dramatic relief.

Cough is a persistent symptom in most patients

RICHARD V. EBERT, M.D., *The American Review of Respiratory Disease, July 1959.*

with emphysema. The sputum production is greatest following a respiratory infection. Many patients with emphysema have a slight decrease in the oxygen saturation of the hemoglobin of the arterial blood and a slight increase in carbon dioxide tension. There appears to be little correlation between the degree of hypoxia and the severity of the dyspnea.

The most serious threat to the life of the patient with emphysema is the sudden increase in hypoxia and hypercapnia which accompanies an exacerbation of the bronchitis. He has a sudden increase in dyspnea and becomes cyanotic, and often disoriented and confused. Cough and fever may be absent, and secretions accumulate in the trachea and bronchi. Administration of oxygen may lead to improvement, or the patient may lapse into coma as a result of an increase in carbon dioxide tension in the arterial blood and resultant respiratory acidosis. Death may occur if treatment is not prompt and effective.

Right heart failure is commonly found in these patients and is manifested by cardiac enlargement, elevated venous pressure, and hepatomegaly. There is no evidence to indicate that this adversely influences the function of the lungs. The heart failure is usually not chronic but clears when the acute bronchial infection subsides and the hypoxia improves.

The prognosis of emphysema is not well defined. In part this is related to difficulties of classification and definition. There are a number of patients who apparently have emphysema but who do not follow the classical clinical course just given.

ASSOCIATED CONDITIONS

One of the controversial aspects of emphysema is its relationship to bronchial asthma. A number of patients with typical emphysema will give a previous history of bronchial asthma. The episodes of dyspnea accompanying acute bronchial infection in emphysema are difficult to differentiate from true bronchial asthma. Hence it is difficult to determine whether previous episodes were asthma or bronchitis. The incidence of pulmonary emphysema in patients with known bronchial asthma is also difficult to establish. The relationship between bronchial asthma and emphysema needs further clarification.

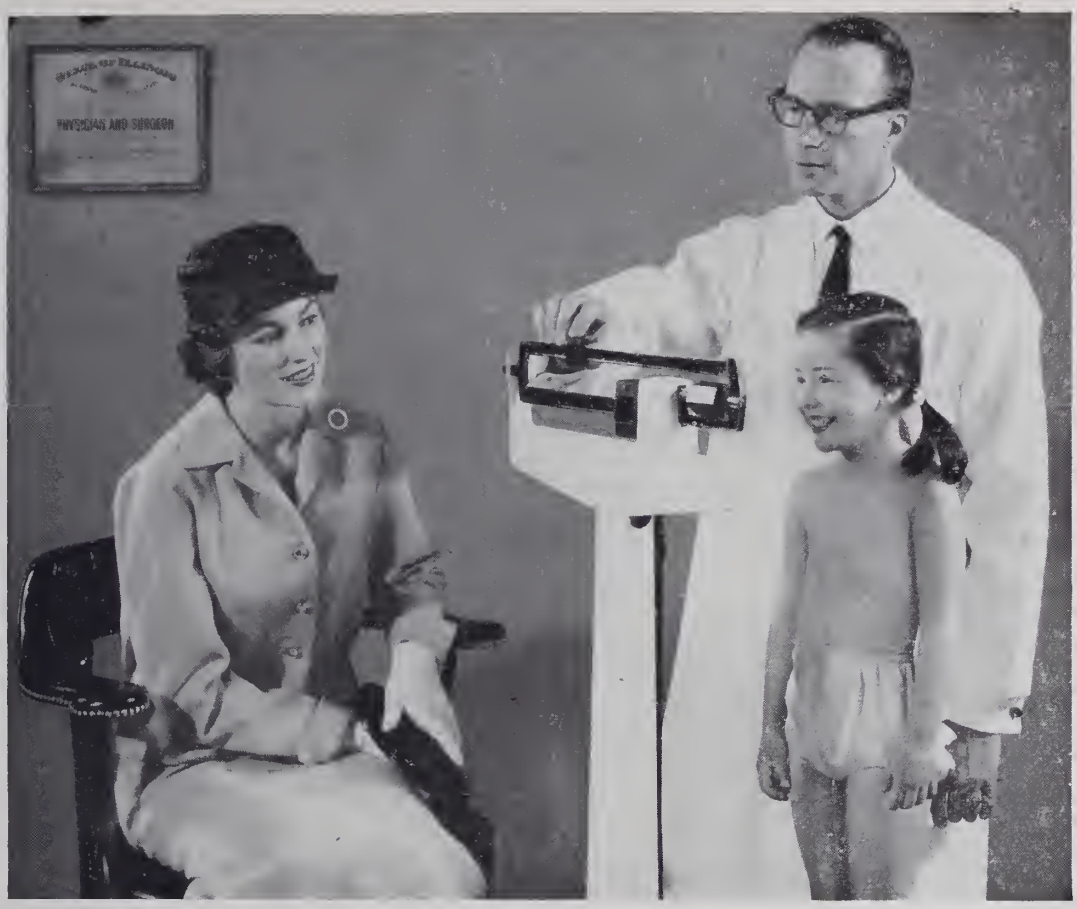
A similar problem exists in the relationship between chronic bronchitis and emphysema. It is clear that chronic bronchitis is often associated with pulmonary emphysema and that acute bronchial infection precipitates the more severe episodes of dyspnea and hypoxia.

There also appears to be a relationship between bronchiectasis and emphysema. A mild cylindrical dilatation of the bronchi is found on the bronchograms of many patients with emphysema, but certain patients have the findings of saccular bronchiectasis. The bronchiectasis precedes by some years the symptoms of emphysema. Moreover, a number of patients with severe bilateral bronchiectasis develop pulmonary insufficiency. There also appears to be an undue incidence of diffuse pulmonary emphysema complicating other chronic inflammatory diseases of the lung. A focal type of emphysema has been described in the lungs of coal miners.

Certain changes in pulmonary function occur with aging. There is a decrease in vital capacity and an increase in residual volume in association with a change in the elastic properties of the lungs. These elderly persons have no respiratory symptoms but if such persons develop bronchitis, the physiologic findings could readily be confused with emphysema.

Many patients with emphysema will demonstrate an increase in the anteroposterior diameter of the chest associated with hyperresonance to percussion and a tendency to obliteration of the cardiac and hepatic dullness. Similar changes occur in many elderly persons without emphysema. Moreover, some patients with emphysema do not exhibit this phenomenon. It would appear that the barrel-chest phenomenon is related to aging changes in the skeleton. For some reason it tends to occur prematurely in patients with emphysema.

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In this study, the weight gained was not lost after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

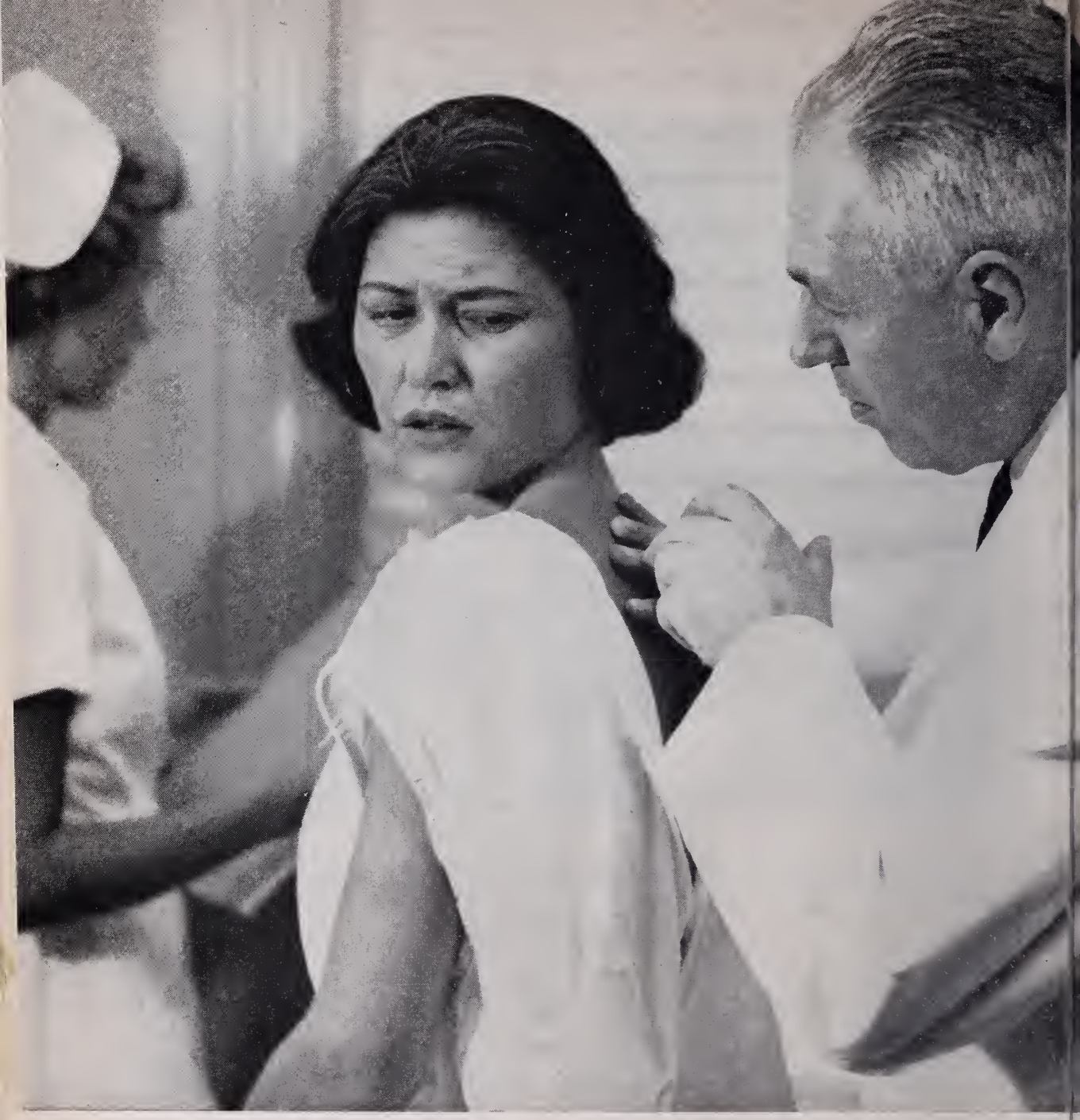
When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

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*Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.



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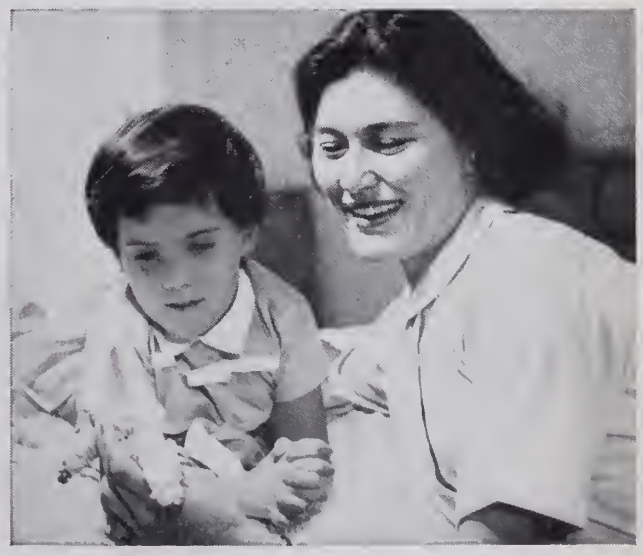
Deprol acts fast to relieve emotional fatigue. It overcomes tiredness and lethargy, apathy and listlessness, thus restoring normal vitality and interest before the fatigue deepens. On Deprol, improvement is achieved without producing liver toxicity, hypotension, psychotic reactions, changes in sexual function or Parkinson-like reactions associated with energizers or phenothiazines.

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and

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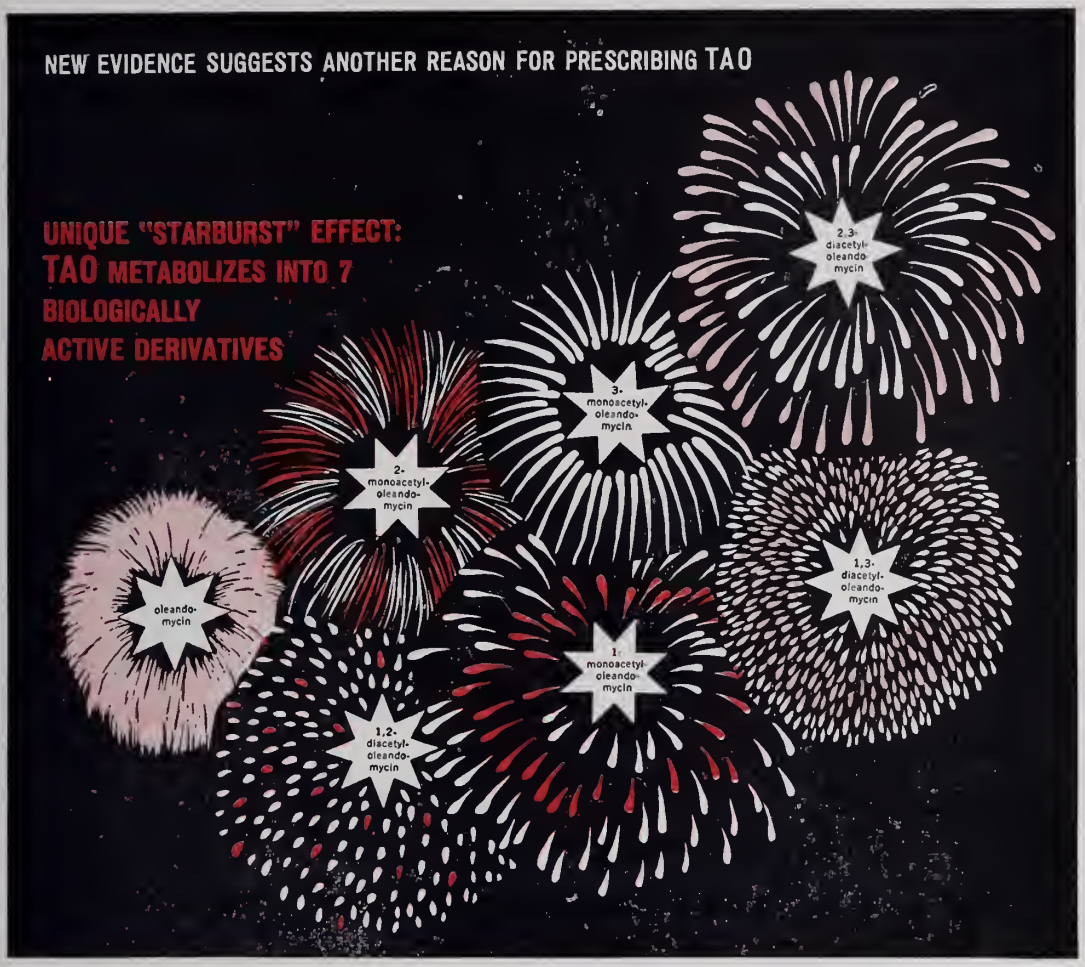
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1. English, A. R., and McBride, T. J.: Proc. Soc. Exper. Biol. & Med. **100**:880 (Apr.) 1959. 2. Celmer, W. D.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 277. 3. English, A. R., and Fink, F. C.: Antibiotics & Chemother. 8:420 (Aug.) 1958.

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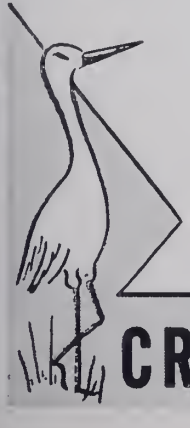
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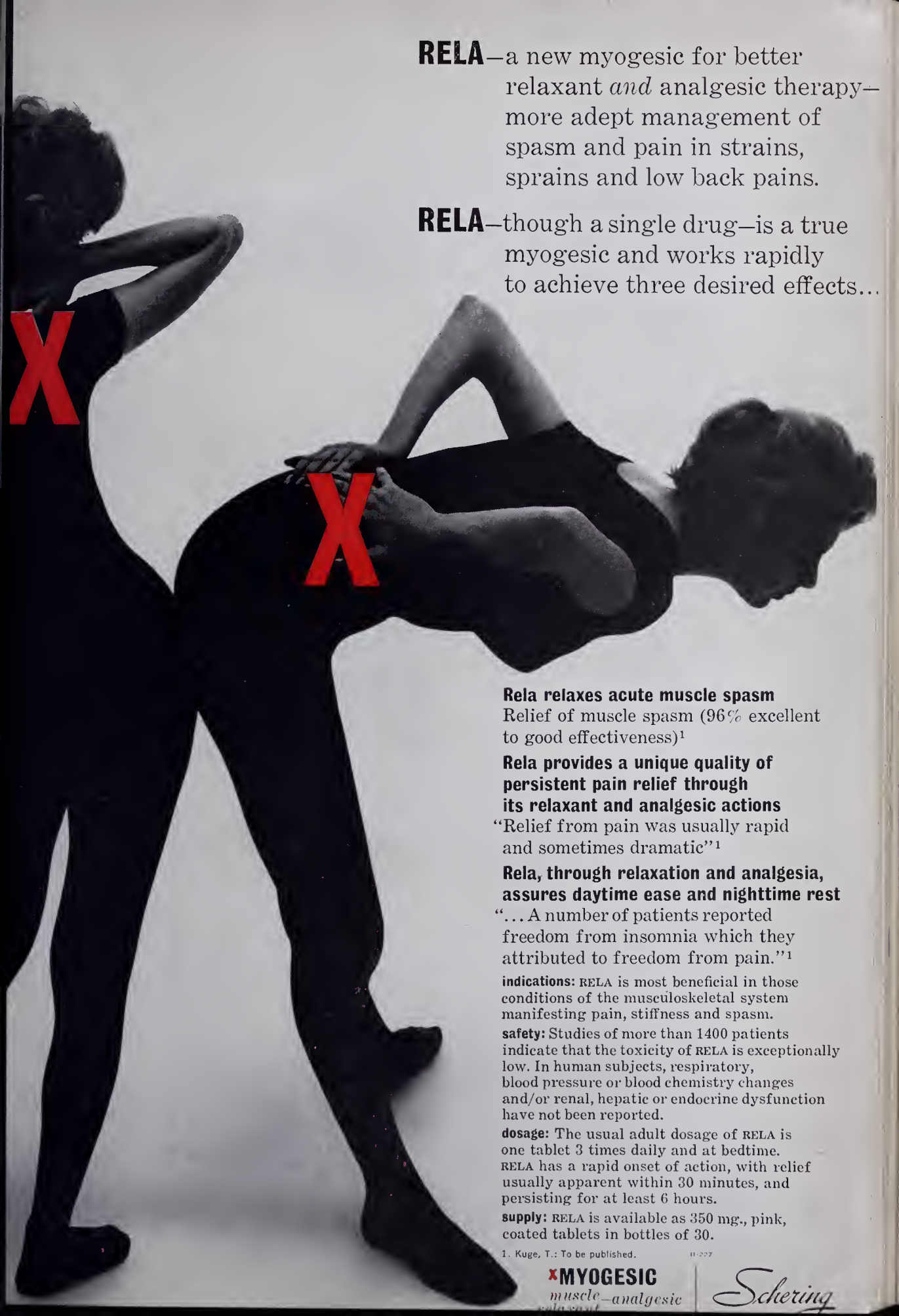
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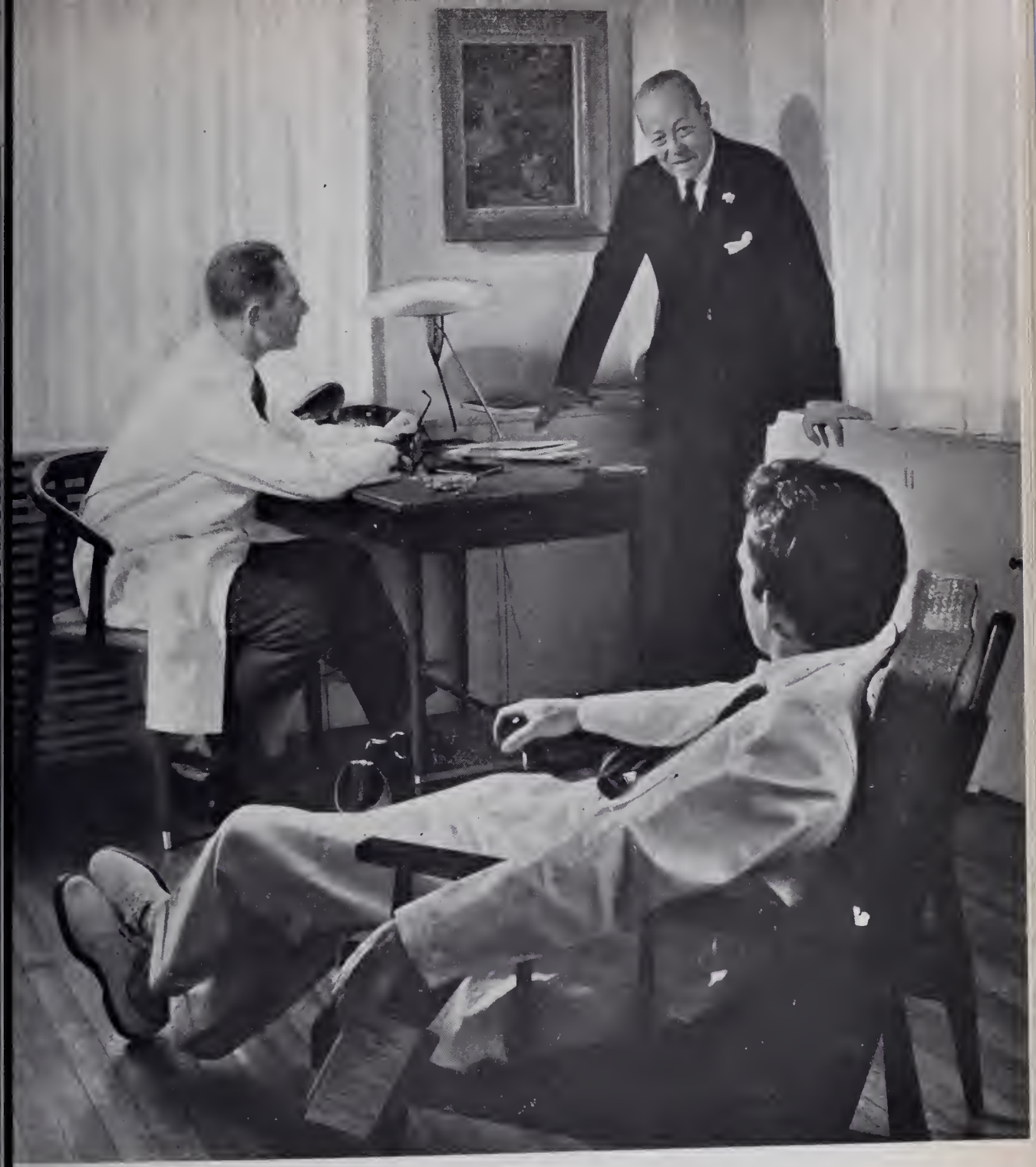
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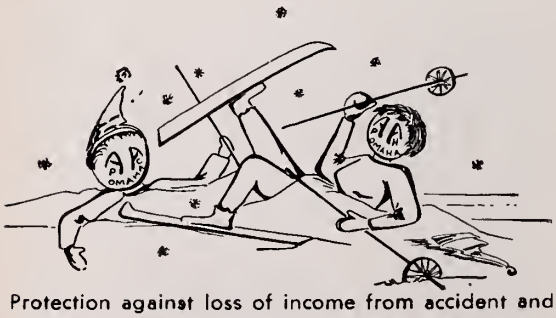
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Case Profile*

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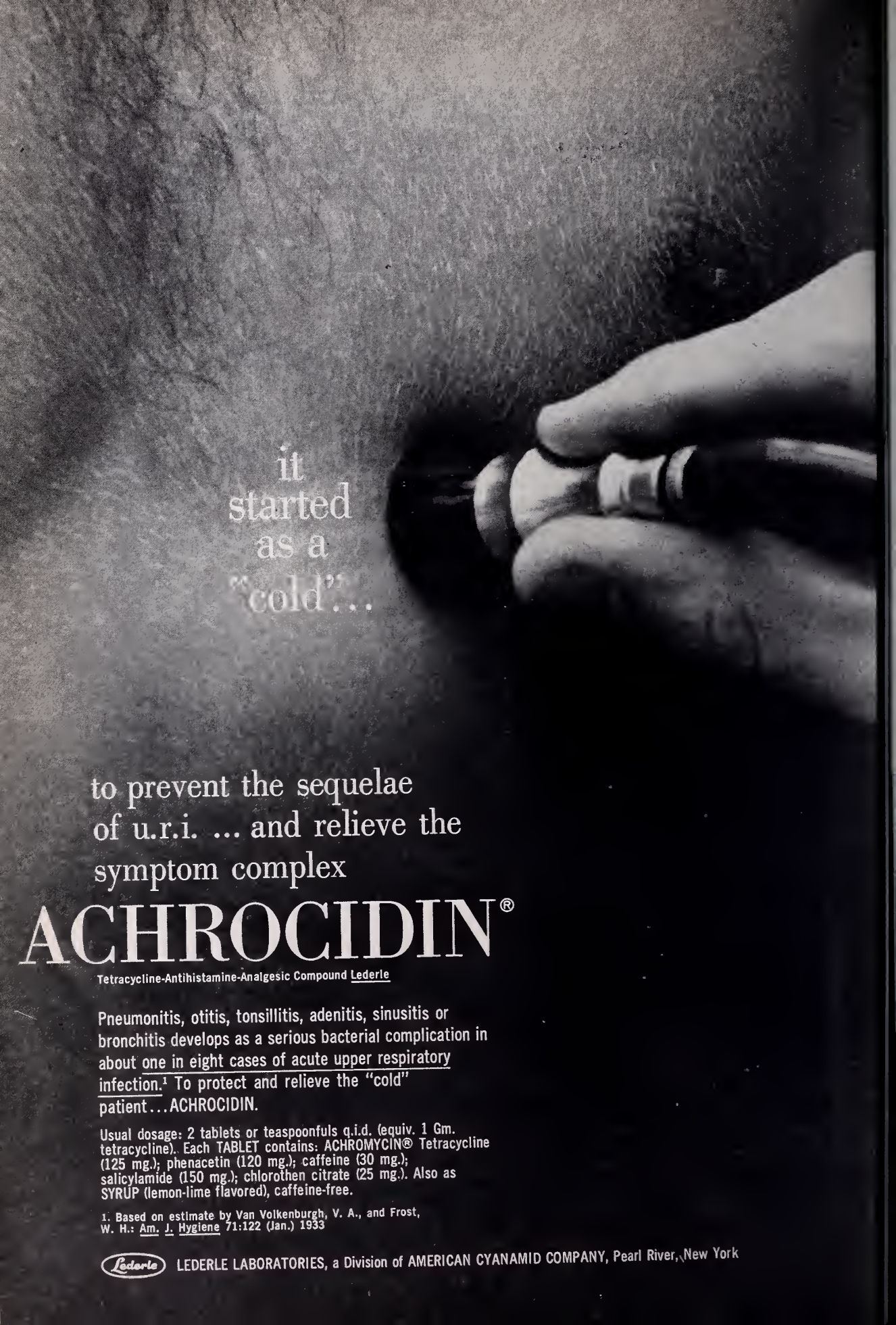
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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

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Ensey, J. E.: Am. J. Obst. 77:155, 1959

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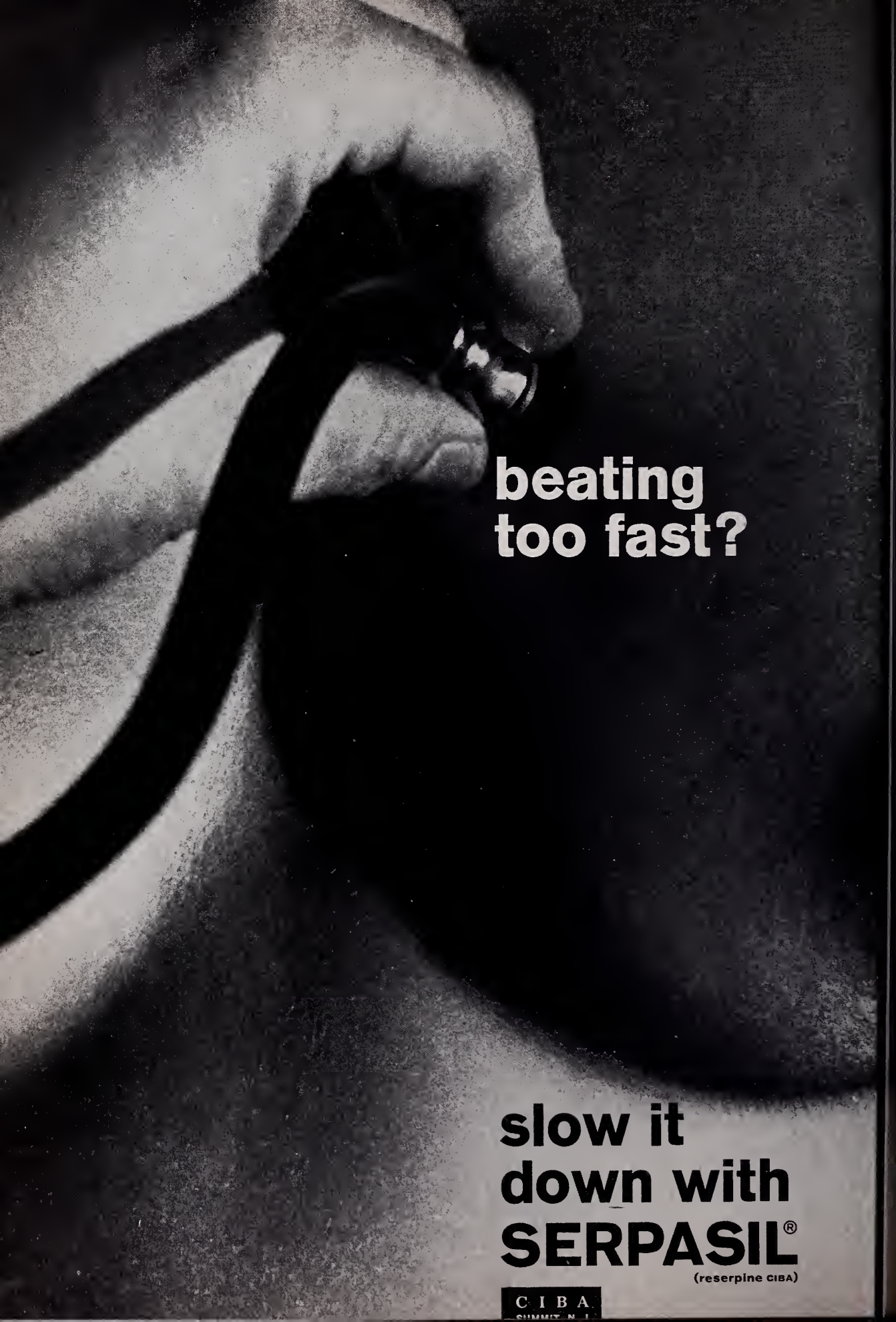
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1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

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Same formula, plus

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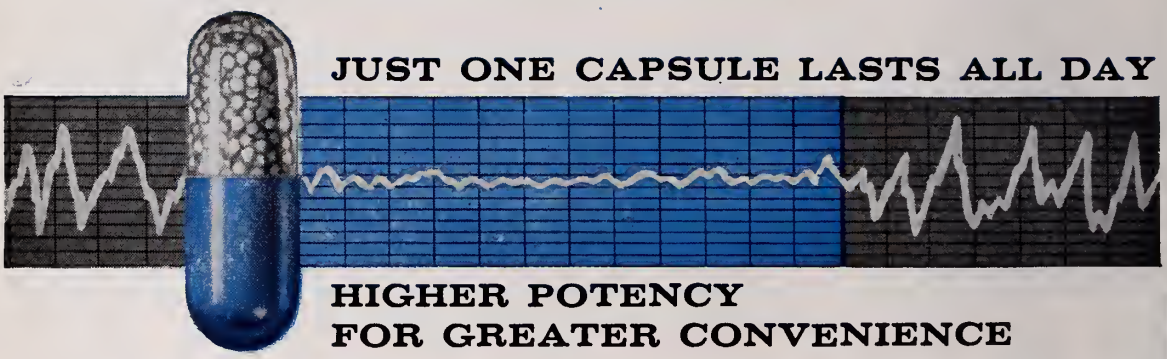
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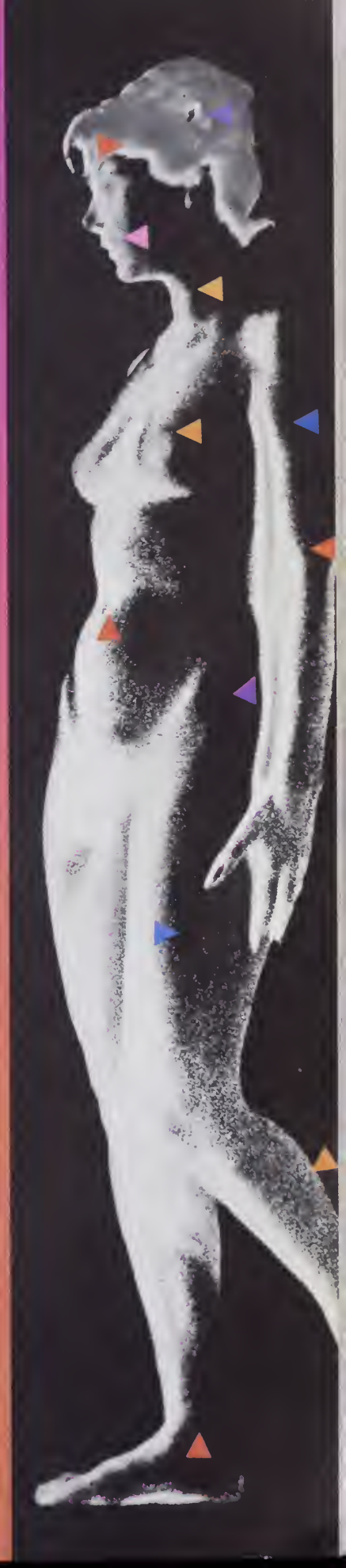
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...providing the desired gradation of potencies for relief of varying intensities of pain

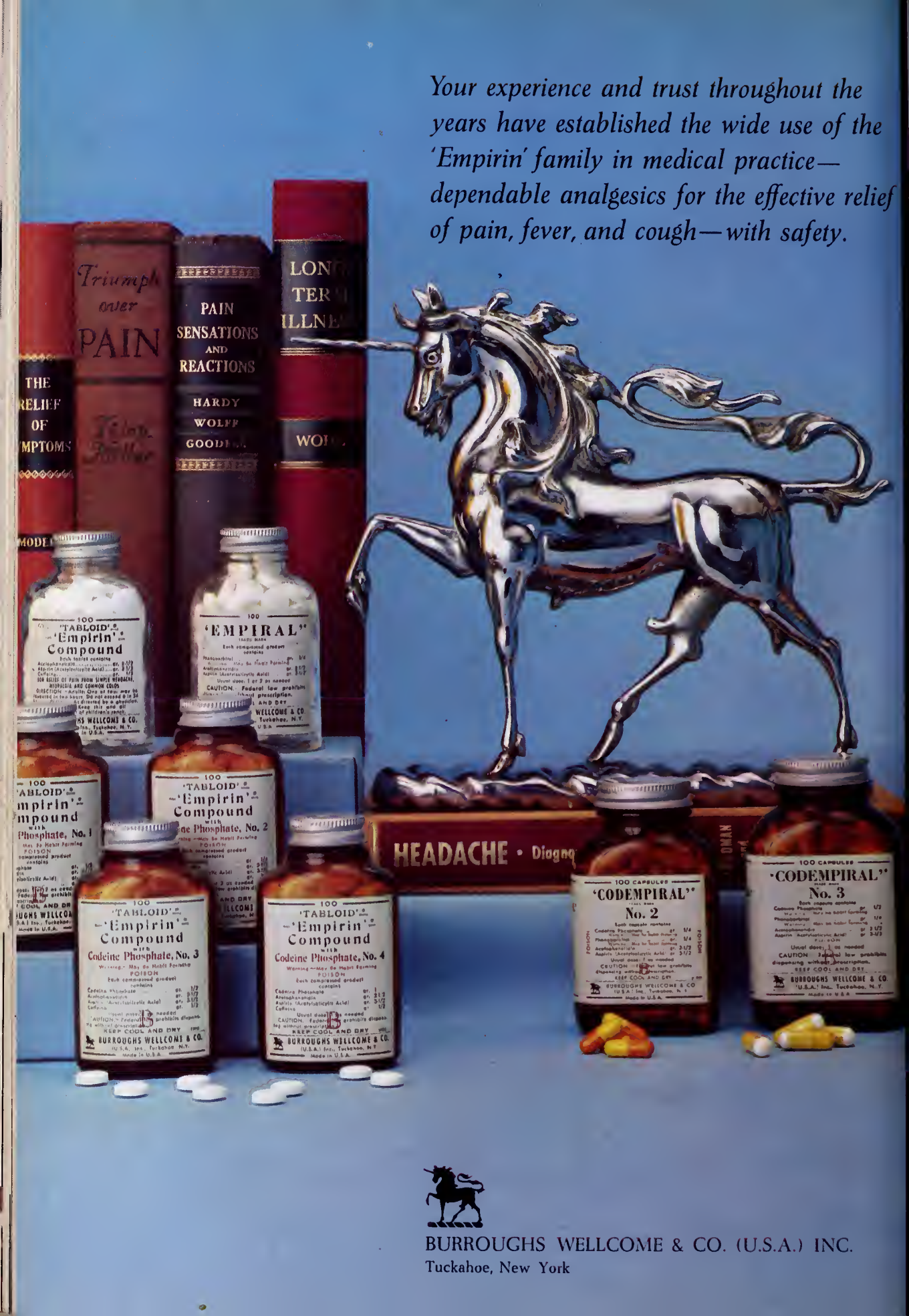
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simple headache
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arthralgias
myalgias
common cold
toothache
earache
dysmenorrhea
neuralgia
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tension headache
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minor surgery
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of all degrees of
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that which
requires morphine

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fevers
dry,
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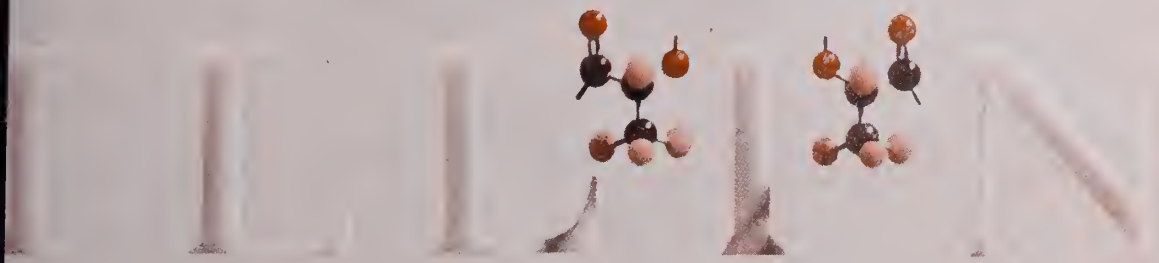
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ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSE

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MANY STAPH STRAINS MORE SENSITIVE TO SYNCILLIN IN VITRO

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FOR HIGHLY EFFECTIVE THERAPY OF THE LARGE VARIETY OF INFECTIONS CAUSED BY SUSCEPTIBLE PATHOGENS... NEW

SYN

Significance of complementary action of isomers in SYNCILLIN

The antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than that of either of its two component isomers alone against many important pathogens, including some penicillin-resistant staphylococci. This phenomenon has been described as *Isomeric Complementarity*.

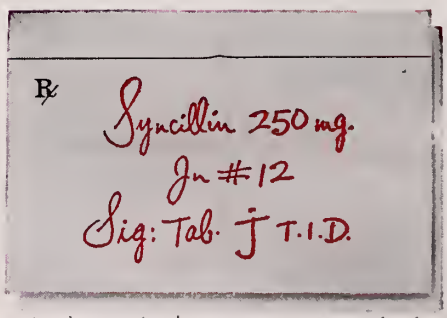
Significance of higher blood levels with SYNCILLIN

Higher blood levels may be of value with organisms of only moderate penicillin sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition, these higher levels may be necessary where there is infection in areas with a poor blood supply.[6] Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue. Also, antibiotic activity of SYNCILLIN is directly proportional to oral dosage. Increasing the dosage may, therefore, enhance the drug's effectiveness in certain cases.

Efficacy of SYNCILLIN against staphylococci and other resistant organisms

Studies have shown that SYNCILLIN is effective *in vitro* against 60 to 75% of hospital "staph" strains, while penicillin G and penicillin V are now effective against only 30 to 50%.[1, 2] Therefore, if clinical judgment indicates the use of penicillin, SYNCILLIN would be expected to be the most effective. However, since some strains are still resistant to SYNCILLIN as well as to the other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment.

There have recently been reports of decreased efficacy of penicillin in streptococcal[3] and gonococcal[4, 5] infections. The emergence of penicillin-resistant gonococci appears to be associated with an increase in the incidence of gonorrhea all over the world. When a less sensitive strain is encountered the higher blood levels produced by SYNCILLIN may be most helpful.



major therapeutic advantages accompany molecular asymmetry

L L I N™

Relation of intermittent gh blood levels SYNCILLIN o antibacterial efficacy

SYNCILLIN, like all clinically available penicillins, is bactericidal. Periodic high blood concentrations are sufficient to permit complete eradication of sensitive pathogens. Continuous high blood levels are not required with SYNCILLIN. According to Eagle,[7] "Soon after penicillin attains effective concentrations, the bacteria cease multiplying; and the bacteriostatic effect persists for a number of hours after penicillin has fallen to concentrations that are wholly ineffective....The therapeutic significance of this postpenicillin recovery period is enhanced by the fact that the recovering bacteria, damaged but not killed by the previous exposure to penicillin, are abnormally susceptible to the host defenses. In consequence, the bactericidal process *in vivo* continues for many hours after the drug itself has fallen to ineffective concentrations."

Reduced rate of inactivation SYNCILLIN by staph penicillinase

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms. SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V and penicillin G. Penicillinase from *B. cereus* likewise inactivates SYNCILLIN less rapidly than penicillin V and G. But this would not impede the therapeutic use of this penicillinase in allergic reactions. This is because the massive dosage with which this enzyme is administered would effectively destroy SYNCILLIN in the body.

References: 1. Wright, W. W.: Microbiology Report to Bristol Laboratories Inc. 2. Kligman, A.; Morigi, E. M. E.; Wheatley, W. B., and Albright, H.: Paper presented at the Seventh Antibiotic Symposium, November 4-6, Washington, D.C. 3. Editorial: New England J. Med. **261**:305 (Aug. 6) 1959. 4. King, A.: Lancet **1**:651 (March 29) 1958. 5. Epstein, E.: J.A.M.A. **169**:1055 (March 7) 1959. 6. Kass, E. H.: Am. J. Med. **18**:764 (May) 1955. 7. Eagle, H.: J. Bact. **58**:475, 1949.

Indications: SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins. SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage: 125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals. Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions: At the present time it is not possible to draw definite conclusions regarding the incidence of allergenicity to SYNCILLIN or its cross-allergenicity with natural penicillins. *Therefore, the usual precautions for oral penicillin therapy should always be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care. Administration of oral penicillin, in rare instances, may provoke acute anaphylaxis, particularly in penicillin-sensitive individuals.
Diarrhea has been reported occasionally following heavy dosage. If this occurs, lengthen the interval between dosages.
If superinfection occurs during therapy, appropriate measures should be taken. Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply: 125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

BRISTOL LABORATORIES, Division of Bristol-Myers Company, SYRACUSE, NEW YORK

Preferably, antibiotic therapy should be based on pretreatment culture of the offending pathogen, but in bacterial pneumonia the problem may well be too pressing to permit the required delay of 24 to 48 hours. A differential diagnosis among bacterial pneumonias, based on such clinical grounds as speed of onset, sepsis and pain may guide the choice of antibiotic for initiation of therapy.

Should clinical judgment dictate that antibiotic therapy be started immediately, at the same time a sputum sample or a subglottic swab can be sent to the laboratory for culture and sensitivity studies. If the response to the first antimicrobial agent proves unsatisfactory, a reasonable basis for changing therapy will then be at hand.

Choosing the Antibiotic

Since therapy must be started at once for bacterial pneumonia, it is advisable to choose a broad-spectrum antibiotic that quickly produces high levels of active agent (e.g., tetracycline phosphate complex, TETREX). Such an antibiotic probably has the best chance of controlling the pathogen, whether it be gram-negative or gram-positive. And if the laboratory report shows that the invading organism is much less sensitive to tetracycline than to other agents, the patient can then be changed to an appropriate antibiotic. If the difference in sensitivity is slight, then the possibility of side effects, sensitization, and toxicity should be evaluated before changing therapy to another antibiotic.

The greatest number of bacterial pneumonias are caused by pneumococci, which respond very well to penicillin, tetracycline, and chloramphenicol. Also, these antibiotics are usually effective against the other gram-positive coccal pneumonias. But penicillin is ineffective against the viral pneumonias and the gram-negative *Hemophilus influenzae* and *Klebsiella pneumoniae*. Although *K. pneumoniae* causes only about 1 to 2 per cent of pneumonia cases on the average,[1] these are apt to be acute and fulminating (Friedländer's pneumonia), with a high mortality rate if not effectively treated. Since pneumococcal pneumonia may be difficult to distinguish clinically from Friedländer's, except by gram-stained sputum smear, it may be wiser to start treatment with an agent also effective against Klebsiella.

Penicillin, however, in addition to having a limited spectrum, also causes many minor and some serious sensitivity reactions. In a recent survey[2] it was found that penicillin produced severe skin reaction. But most important was the observation that anaphylactic shock, with a fatality rate of about 9 per cent, was the most frequent serious reaction. Such severe reactions are almost always associated with parenteral administration.

Tetracycline is also clinically effective in primary atypical pneumonia.[3]

The tetracyclines (e.g., TETREX) have the advantage of a broad range of antimicrobial activity and low toxicity. And in addition, the physician does not have to trouble himself or his patients with repeated blood studies when he prescribes TETREX. Minor reactions such as gastric upsets or mild skin rashes occur occasionally. The most serious side effects are staphylococcal and monilial overgrowth, but these are rare and can be adequately controlled.

No one would deny that appropriate antibiotic therapy has greatly reduced morbidity and saved many lives of patients with bacterial pneumonia. Nevertheless, general supportive measures in the care of patients remain important even today. Especially in the desperately ill patient, antibiotics are not considered as substitutes for the individual evaluation, clinical observation and judgment of the physician.

***Some Micro-organisms Susceptible[a] to Tetracycline* (TETREX)[b]**

Streptococcus; Staphylococcus; Pneumococcus; Gonococcus; Meningococcus; *C. diphtheriae; B. anthracis; E. coli;* Proteus; *A. aerogenes; Ps. aeruginosa; K. pneumoniae;* Shigella; Brucella; *P. tularensis; H. influenzae; T. pallidum;* Rickettsiae; Viruses of psittacosis and ornithosis, lymphogranuloma inguinale, primary atypical pneumonia; *E. histolytica; D. granulomatosis.*

a Some strains are not susceptible.

b Table adapted from Goodman, L. S., and Gilman, A.: The Pharmaceutical Basis of Therapeutics, 2nd edition, New York, The Macmillan Co., 1956, pp. 1322-1323.

References: 1. Wood, W. E., Jr.: In: A Textbook of Medicine. Edited by Cecil, R. L., and Loeb, R. F., 9th edition, Philadelphia, W. B. Saunders Co., 1955, p. 145. 2. Welch, H.; Lewis, C. H.; Weinstein, H. I., and Boeckman, B. B.: Severe reactions to antibiotics. A nationwide survey. Antibiotic Med. & Clin. Ther. 4:800 (Dec.) 1957. 3. Keefer, C. S.: The choice of an anti-infective agent. In: Drugs of Choice, 1958-1959. Edited by Walter Modell, St. Louis, The C. V. Mosby Co., 1958, p. 135.

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IN LOW BACK PAIN...
more and more
reports show that

Trancopal®

a true "tranquilaxant"
keeps the patient
on the job

THE FIRST TRUE "TRANQUILAXANT"

Trancopal®

relieves painful muscle spasm and relaxes the patient



Impressive numbers of patients with low back pain and other musculospastic conditions treated with Trancopal have been freed of symptoms and enabled to return to their usual activities, according to newly published clinical reports. In a recent study by Lichtman,[1] Trancopal brough excellent to satisfactory muscle relaxation to 817 of 879 patients. The patients in this group suffered from skeletal muscle spasm associated with low back pain (361 cases), stiff neck (128 cases), bursitis (177 cases), and other skeletal muscle disorders (213 cases). Side effects were rare (2 per cent of patients), and it was not necessary to discontinue medication in any of the patients. Lichtman comments: "Chlormethazanone [Trancopal] not only relieved painful muscle spasm, but allowed the patients to resume their normal activities with no interference in performanc of either manual or intellectual tasks."[2]

When you prescribe Trancopal for musculoskeletal disorders, you can confidently expect that your patients will be relieved of the pain and stiffness. You can be sure of their speedy return to everyday work and recreation.

Mullin and Epifano call Trancopal "...a very effective skeletal muscle spasmolytic."[3] They found that Trancopal brought good to excellent relief to all of 39 patients with skeletal muscle spasm related to trauma, bursitis, rheumatoid arthritis, osteoarthritis, and intervertebral disc syndrome. (No side effects were noted except that one patient had slight dryness of the mouth.)

The pattern is similar in every new series reported: Ganz,[4] DeNyse,[5] Shanaphy[6] and Stough

Trancopal is a true "tranquilaxant"

Trancopal "...combines the properties of tranquilization and skeletal muscle relaxation with no concomitant change in normal consciousness."[6]

Relieves dysmenorrhea



Trancopal not only is valuable in treating patients with low back pain and other musculoskeletal disorders, but is also very effective in bringing relief from menstrual cramps and discomfort. Shanaphy suggests that Trancopal may help the patient by its combination of muscle relaxant and tranquilizing actions, and he finds that "...the continued use of chlormezanone [Trancopal] as a therapeutic agent in dysmenorrhea is advisable."[6] Trancopal was effective in 82 per cent of his series of 50 patients. In another study, which dealt with 52 adolescent girls and 23 women, Stough[7] reported that Trancopal gave complete or moderate relief in 86.4 per cent.

Alleviates tension

And, of course, Trancopal is also very useful in the treatment of patients in anxiety and tension states. As Ganz says, "...a most valuable drug for relieving tension, apprehension and various psychogenic states...allows the patient to use his energies in a more productive manner in overcoming his basic problems."[4]

Trancopal

a true "tranquilaxant"

that relieves skeletal muscle spasm and relaxes psychogenic tension without troublesome side effects, and keeps the patient on the job.

Indicated for...

Musculoskeletal disorders		Psychogenic disorders
Low back pain (lumbago)	Fibrositis	Anxiety and tension states
Neck pain (torticollis)	Ankle sprain, tennis elbow	Dysmenorrhea
Bursitis	Myositis	Premenstrual tension
Rheumatoid arthritis	Postoperative muscle spasm	Asthma
Osteoarthritis		Angina pectoris
Disc syndrome		Alcoholism

Now available in two strengths:

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Trancopal Caplets, 200 mg. (green colored, scored), bottles of 100.

Dosage: Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.



(brand of chlormezanone)

References: 1. Lichtman, A. L.: Scientific Exhibit meeting of the International College of Surgeons, Miami Beach, Fla., Jan. 4-7, 1959. 2. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 3. Mullin, W. G., and Epifano, Leonard: *Am. Pract. & Digest Treat.* 10:1743, Oct., 1959. 4. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 5. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 6. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 7. Stough, A. R.: *J. Oklahoma M. A.* 52:575, Sept., 1959.

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whenever there is inflammation, swelling, pain

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5 days of classic therapy — after 48 hours of VARIDASE

as in cellulitis*

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VARIDASE mobilizes the natural healing process, by accelerating fibrinolysis, to condition the patient for successful primary therapy. Increases the penetrability of the fibrin wall, for easy access by antibodies and drugs . . . without destroying limiting membrane . . . and limits infiltration. Prescribe VARIDASE Buccal Tablets routinely in infection or injury.

*Innerfield, I.: Clinical report cited with permission.

VARIDASE BUCCAL Tablets contain:
10,000 Units Streptokinase, 2,500 Units Streptodornase.

Supplied: Boxes of 24 and 100 tablets

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This is Panalba performance...





in sinusitis

. . . into a mixed culture of the four organisms commonly involved in sinusitis . . . *Str. hemolyticus, D. pneumoniae, H. influenzae* and *Staph. aureus* (in this case a resistant strain) . . . we introduce the five most frequently used antibiotics.

Twenty-four hours later (in this greatly enlarged photograph), note that only *one* of the five leading antibiotics has stopped *all* the organisms, including the resistant staph! This is Panalba.

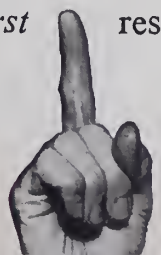
In your next patient with sinusitis . . . in *all* your patients with potentially-serious infections . . . provide this extra protection with your prescription:

Dosage—1 or 2 capsules 3 or 4 times a day.
Supplied—Capsules containing Panmycin phosphate equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin as novobiocin sodium, in bottles of 16 and 100.
Now available: new Panalba Half-Strength Capsules in bottles of 16 and 100.

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The broad-spectrum antibiotic of *first* resort



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Security lies in prescribing the
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Clinical samples and literature sent to physicians on request

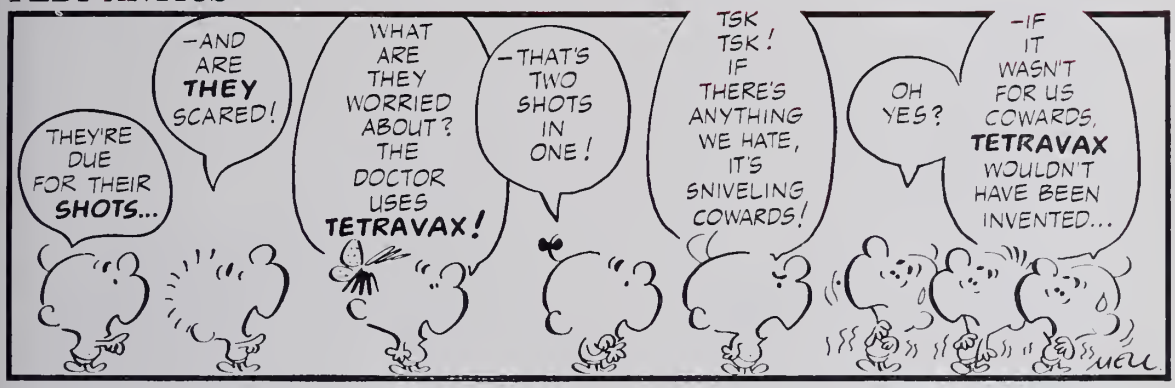
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now you can immunize against more *diseases...with* fewer *injections*

Dose: 1 cc.
Supplied: 9 cc. vials in *clear plastic* cartons. Package circular and material in vial can be examined without damaging carton. Expiration date is on vial for checking even if carton is discarded.



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Lifts depression...



You see an improvement within a few days
Thanks to your prompt treatment and the quick, smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in a few days.* She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... swiftly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient – *they often aggravate anxiety and tension.* And although amphetamine-barbiturate combinations may counteract excessive stimulation – *they often deepen depression.*

In contrast to such "seesaw" effects, Deprol lifts depression as it calms anxiety – both at the same time.

Acts swiftly – the patient often feels better within a few days. Unlike the delayed action of other drugs which may take two to six weeks to bring results, Deprol's smooth, immediate action relieves the patient quickly – often within a few days.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function – frequently reported with other drugs.



BIBLIOGRAPHY *(10 clinical studies, 714 patients)*:

1. Alexander, L. (35 patients): Chemotherapy of depression – Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Botemon, J. C. and Carlton, H. M. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Bell, J. L., Touber, H., Sonty, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **4.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **5.** McClure, C. W., Papas, P. N., Speare, G. S., Polmer, E., Slottery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression–New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **6.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **7.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **8.** Ruchworger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **9.** Settel, E. (52 patients) Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy. In press, 1959. **10.** Splitter, S. R. (84 patients): The care of the anxious and the depressed. Submitted for publication, 1959.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d.

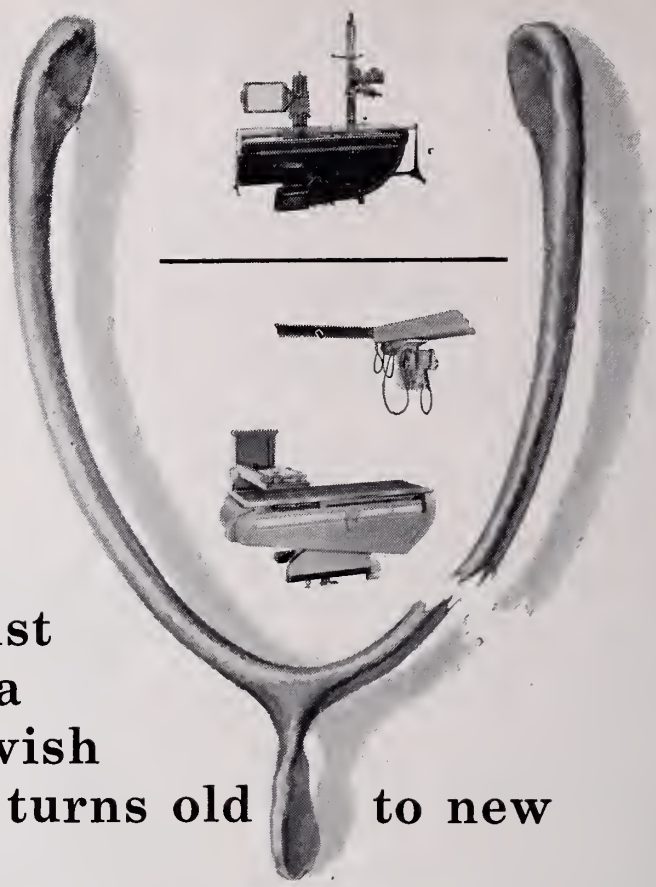
Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

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NIAMID lessens the need for narcotics in the depressed cancer patient and appears to potentiate pain-relieving agents. As pain is reduced and mental outlook improves, apprehension and depression are replaced by a brighter and more alert attitude, and appetite returns. The family, too, is cheered by the improvement in the patient's condition. With NIAMID therapy, patient care becomes noticeably less demanding.

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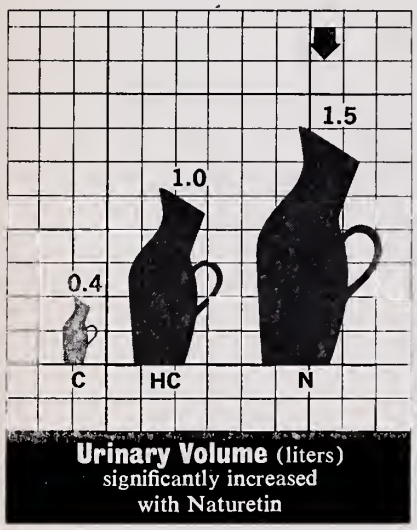
more closely approaches the ideal diuretic

Naturetin

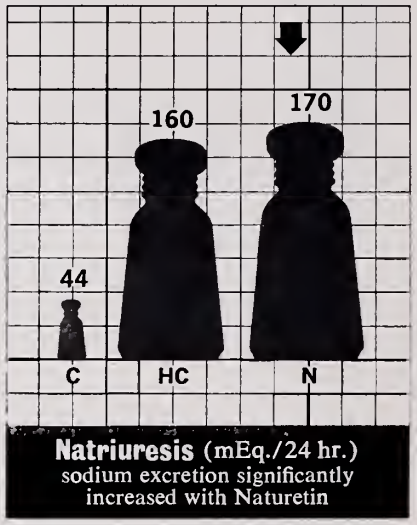
Squibb Benzydroflumethiazide

"When compared to other members of this heterocyclic group of compounds, this drug [NATURETIN] shows a significantly increased natriuresis and decreased loss of potassium and bicarbonate. In this respect it more closely approaches a natural or 'ideal diuretic.' It is effective upon continuous administration and causes no significant serum biochemical changes. It is effective in a wide variety of edematous and hypertensive states and represents a significant advance in diuretic therapy." *Ford, R.V.: Pharmacological observations on a more potent benzothiadiazine diuretic; accepted for publication by the American Heart Journal.*

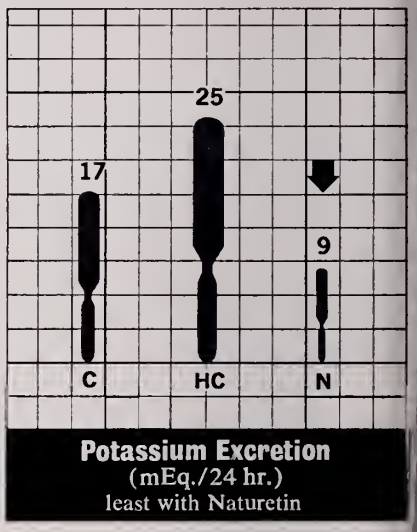
Comparison of electrolyte excretion pattern for the 24 hours following typical doses of chlorothiazide, hydrochlorothiazide, and Naturetin[1]



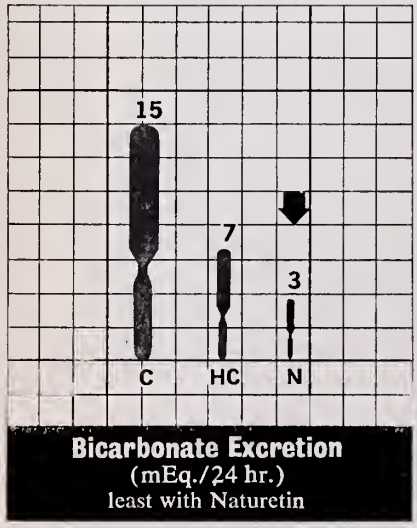
Urinary Volume (liters)
significantly increased
with Naturetin



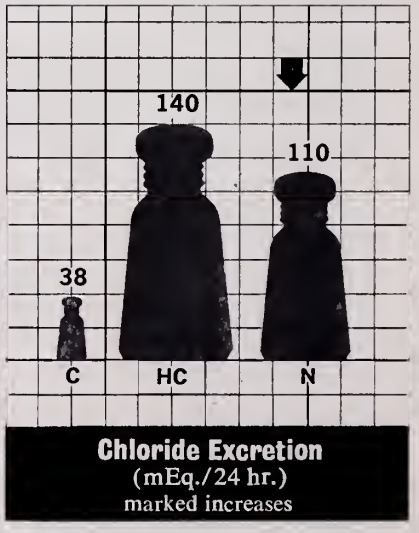
Natriuresis (mEq./24 hr.)
sodium excretion significantly
increased with Naturetin



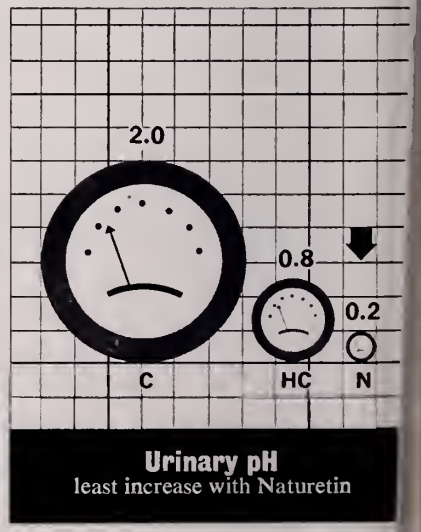
Potassium Excretion
(mEq./24 hr.)
least with Naturetin



Bicarbonate Excretion
(mEq./24 hr.)
least with Naturetin



Chloride Excretion
(mEq./24 hr.)
marked increases



Urinary pH
least increase with Naturetin

Typical Doses: Chlorothiazide—1,000 mg.; Hydrochlorothiazide—50 mg.; Naturetin (Benzydroflumethiazide)—5 mg.

1. Adapted from: Ford, R. V., Squibb Clin. Res. Notes 2:1 (Dec.) 195

A single 5 mg. tablet once a day provides all these advantages[2]

- prolonged action — in excess of 18 hours
- convenient once-a-day dosage
- low daily dosage — more economical for the patient
- no significant alteration in normal electrolyte excretion pattern
- repetitively effective as a diuretic and antihypertensive
- greater potency mg. for mg.—more than 100 times as potent as chlorothiazide
- potency maintained with continued administration
- low toxicity — few side effects — low salt diets not necessary
- comparative studies with chlorothiazide, hydrochlorothiazide, and Naturetin disclose that smallest doses of Naturetin produce greater weight loss per day
- in hypertension, Naturetin, alone or in combination with other antihypertensives, produces significant decreases in mean blood pressure and other favorable clinical effects
- purpura and agranulocytosis not observed
- allergic reactions rarely observed

[2]Reports (1959) to the Squibb Institute for Medical Research.

Naturētin —*Indications:* in control of edema when diuresis is required, in congestive heart failure, in the premenstrual syndrome, nephrosis and nephritis, cirrhosis with ascites, edema induced by drugs (certain steroids); in the management of hypertension, used alone, combined with Raudixin (Squibb Rauwolfia Serpentina Whole Root), or with other antihypertensive drugs, such as ganglionic blocking agents.

Contraindications: none, except in complete renal shutdown.

Precautions: when Naturetin is added to an antihypertensive regimen including hydralazine, veratrum, and/or ganglionic blocking agents, immediate reduction must be made in the dosage for all preparations; the dosage for ganglionic blocking agents must be decreased by 50% to avoid a precipitous drop in blood pressure. This also applies if these hypotensive drugs are added to an established Naturetin regimen . . . in hypochloremic alkalosis with or without hypokalemia . . . in cirrhotic patients or those on digitalis therapy when reductions in serum potassium are noted . . . in diabetic patients or those predisposed to diabetes . . . when increased uric acid concentrations are noted . . . when signs—leg or abdominal cramps, pruritus, paresthesia, rash—suggestive of hypersensitivity, are noted.

Naturētin —*Dosage: in edema,* average dose, 5 mg., once daily, preferably in the morning; to initiate therapy, up to 20 mg., once daily or in divided doses; for maintenance, 2.5 to 5.0 mg., daily in a single dose. *In hypertension:* suggested initial dose, 5 to 20 mg. daily; for maintenance, 2.5 to 15 mg. daily, depending on the individual response of the patient. When Naturetin is added to an antihypertensive regimen with other agents, lower maintenance doses of each drug should be used.

Naturētin —*Supplied:* tablets of 2.5 mg. and 5 mg. (scored).

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Disp. #30
Sig: 1 each
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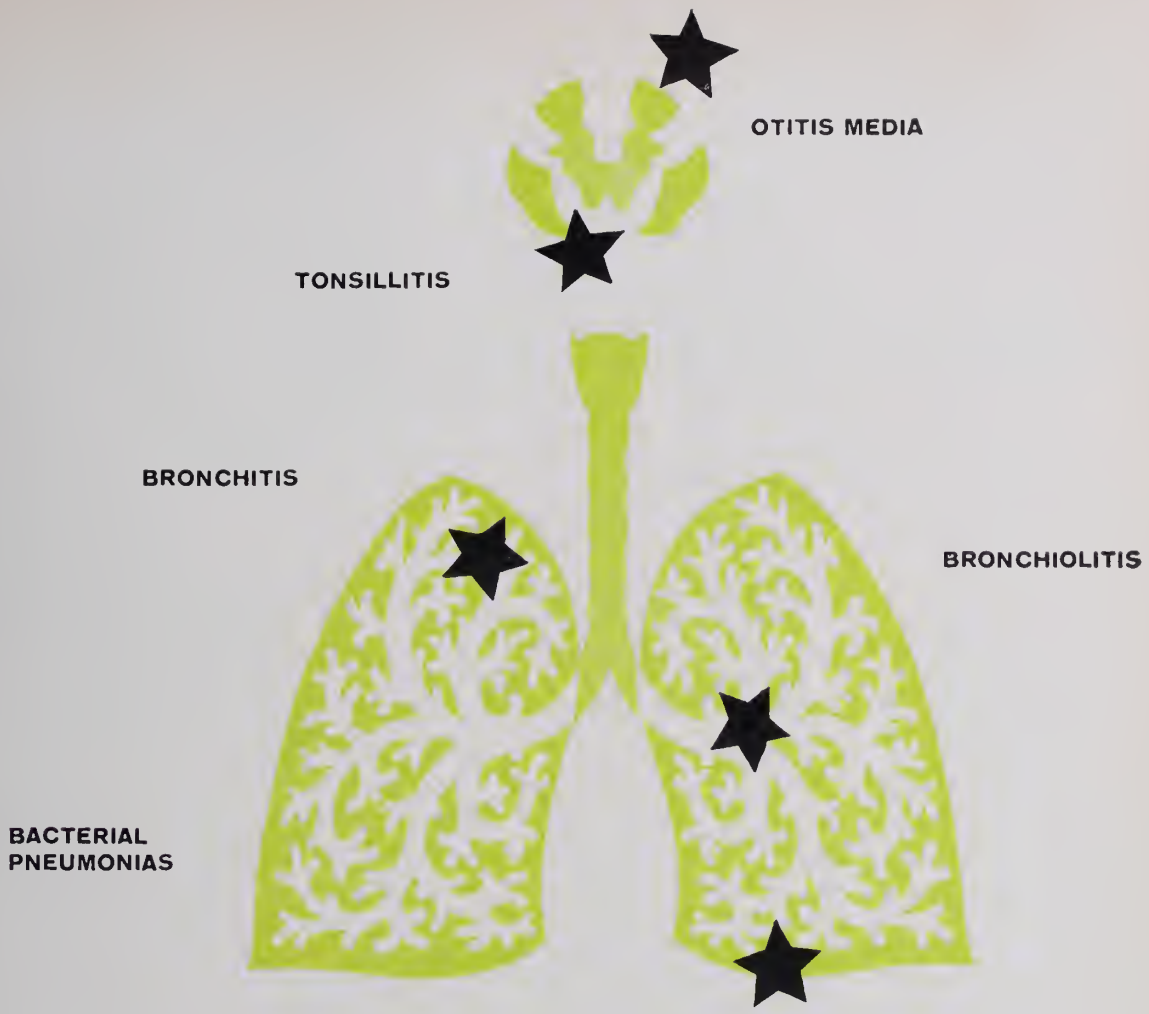
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ALTAFUR is available in tablets of 250 mg. (adult) and 50 mg. (pediatric), bottles of 20 and 100.

1. Lysaught, J. N., and Cleaver, W.: Proceedings of the Detroit Symposium on Antibacterial Therapy (Michigan and Wayne County Academies of General Practice, Detroit, Sept. 12, 1959).

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Dioctyl Sodium Sulfosuccinate (50 mg.) is a wetting agent which lowers surface tension and aids the penetration of intestinal fluids into the fecal mass, providing a moist stool of normal consistency.

EFFECTIVE: Bile influences the constitution as well as the movement of the intestinal contents. The ingredients of major importance are DECHOLIN and desoxycholic acid which increase the flow of bile, lower surface tension, promote emulsification and absorption of fats and mildly stimulate intestinal peristalsis. With dioctyl sodium sulfosuccinate, a good therapeutic effect can be obtained without the danger of toxicity or decreasing effectiveness even when used regularly.

SAFE: Clinical evidence indicates that the constituents of DECHOTYL cause no systemic sensitivity, drug accumulation, habituation or interference with nutrition. Orally, in therapeutic amounts, DECHOTYL is without significant toxic effect. The only side effect following oral administration is diarrhea if the dosage is excessive.

Dosage: *Average adult dose*—Two TRABLETS* at bedtime. Some individuals initially may require 1 to 2 TRABLETS three or four times daily. *Contraindications:* Biliary tract obstruction; acute hepatitis.

Available: TRABLETS,* coated, yellow, trapezoid-shaped; bottles of 100.

*T.M. for AMES trapezoid-shaped tablet.

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the complaint: "nervous indigestion"

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the prescription: a new formulation incorporated in an enteric-coated tablet, providing the multiple actions of widely accepted Donnatal® and Entozyme.®

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"superior to aspirin" — ". . . evidence seems to indicate that the concurrent administration of para-aminobenzoic and salicylic acid [as in Pabalate] produces a more uniformly sustained level for prolonged analgesia and, therefore, is superior to aspirin in the treatment of chronic rheumatic disorders."[1]

In each yellow enteric-coated PABALATE tablet:

Sodium salicylate (5 gr.)	0.3 Gm.
Sodium para-aminobenzoate (5 gr.)	0.3 Gm.
Ascorbic acid	50.0 mg.

For the patient who should avoid sodium

PABALATE®-SODIUM FREE

Same formula as Pabalate, with sodium salts replaced by potassium salts (pink)

For the patient who requires steroids

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Pabalate with Hydrocortisone

In each light blue enteric-coated PABALATE-HC tablet:

Hydrocortisone	2.5 mg.
Potassium salicylate (5 gr.)	0.3 Gm.
Potassium para-aminobenzoate (5 gr.)	0.3 Gm.
Ascorbic acid	50.0 mg.

1. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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reaches all nasal and paranasal membranes *systemically*[1]



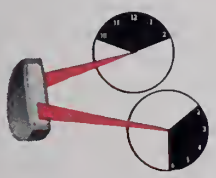
Pharmacologically balanced formula for prompt symptomatic relief

- in nasal and paranasal congestion
- in sinusitis and postnasal drip
- in allergic reactions of the upper respiratory tract

Triaminic*[2,3] *is safer and more effective than topical medication

- transported systemically to *all* respiratory membranes
- provides longer-lasting relief
- presents no problem of rebound congestion
- avoids "nose drop addiction"

Relief is prompt and prolonged because of this special timed-release action:



first — the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then — the core disintegrates to give 3 to 4 *more* hours of relief

Each Triaminic timed-release Tablet provides:
Phenylpropanolamine HCl.....50 mg.
Pheniramine maleate.....25 mg.
Pyrilamine maleate.....25 mg.

Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides: ½ the formulation of the Triaminic Tablet.

Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides: ¼ the formulation of the Triaminic Tablet.

Dosage (to be administered every 3 or 4 hours): *Adults* — 1 or 2 tsp.; *Children 6 to 12* — 1 tsp.; *Children 1 to 6* — ½ tsp.; *Children under 1* — ¼ tsp.

1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

the leading oral nasal decongestant...

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timed-release tablets and juvelets
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Allays anxiety[2]

Phenyltoloxamine DHC 50 mg. Mild, non-phenothiazine, safe with a low sedative component. Seemingly specific for control of the type anxiety seen in asthma.

Usual Dose: *Adults:* For the attack, one or two tablets.
Prophylactically, one tablet every four hours.
Children: (6 to 12 years) One-half the adult dose.

1. Miller, H., and Baruch, D.: Practice of Psychosomatic Medicine as Illustrated in Allergy, Blakiston Company, 1956. 2. Swartz, H: Ephoxamine in the Symptomatic Treatment of Bronchial Asthma, Current Therapeutic Research, 1 (Nov.) 1959.

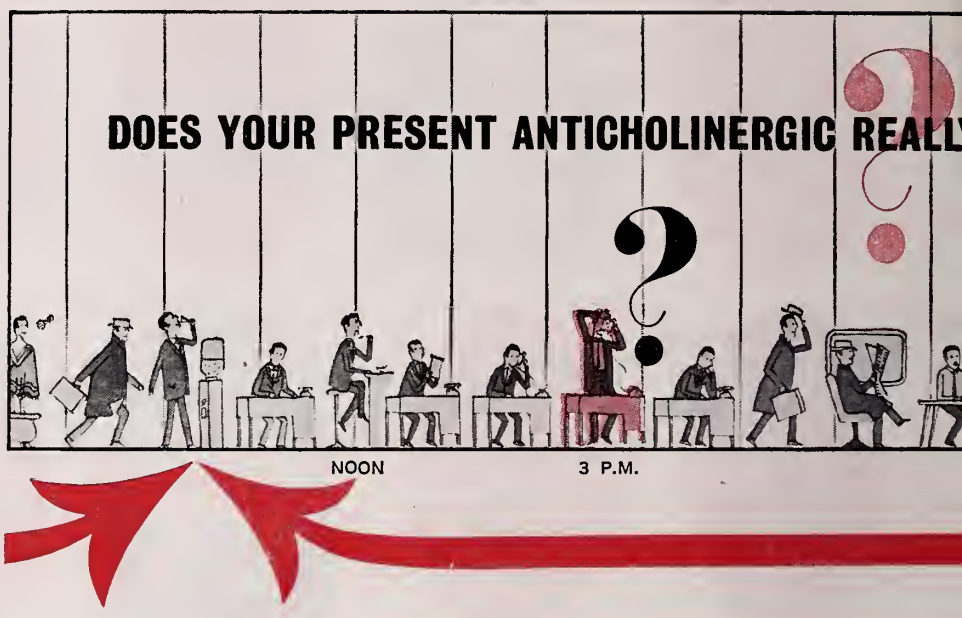
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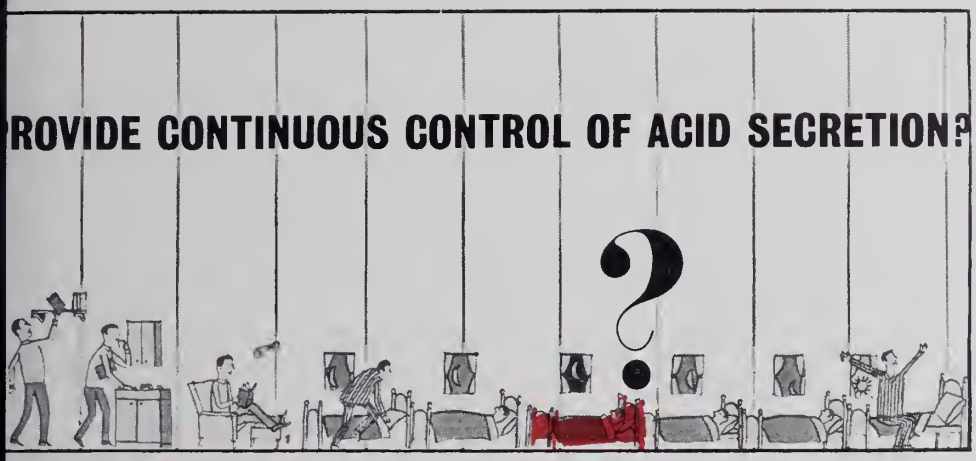
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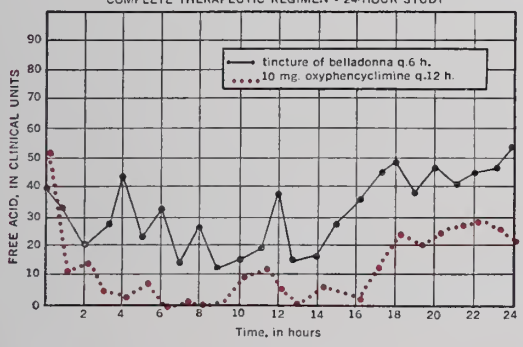
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References: 1. McHardy, G., et al.: J. Louisiana M. Soc. 111:290 (Aug.) 1959. 2. Steigmann, F.: Study conducted at Cook County Hospital, Chicago, Illinois, in press. 3. Kemp, J. A.: Antibiotic Med. & Clin. Therapy 6:534 (Sept.) 1959. 4. Leming, B. H., Jr.: Clin. Med. 6:423 (Mar.) 1959. 5. Data in Roerig Medical Department files.

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BERGENFIELD	Horn's Pharmacy, 475 So. Washington Ave.	DUmont 4-1119
BERGENFIELD	Merit Pharmacy, 8 So. Washington Ave.	DUmont 4-9844
BOONTON	Preston Drugs, Del's Village Shopping Center	DEerfield 4-3466
BOUND BROOK	Lloyd's Drug Store, 305 East Main St.	ELliot 6-0150
BUTLER	Pink's Pharmacy, 178 Main St.	BUtler 9-0090, 9-1063
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CLOSTER	Mid Town Pharmacy, 237 Closter Dock Road	CLoster 5-0070
DOVER	Leslie's Drugs, Inc., 9 East Blackwell St.	FOxcroft 6-1405
DUMONT	Lenrow's Pharmacy Inc., 10 W. Madison Ave.	DUmont 4-0842-1500
EDISON TOWNSHIP	Walter's Pharmacy, 1034 Amboy Ave.	LIberty 8-2614
EMERSON	Emerson Pharmacy, 201 Kinderkamack Road	COlfax 2-4999
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HIGHLANDS	Highlands Pharmacy, 148 Bay Ave.	HIghlands 3-1058
JERSEY CITY	The Cole Pharmacy, Inc., 710 Grand St.	Delaware 3-9294
JERSEY CITY	J. B. Feinberg Pharmacy, 659 Newark Ave.	OLdfield 3-6376
JERSEY CITY	Honiberg Drug & Surgical Supply Co., 618 Newark Ave.	SWarthmore 8-6700
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JERSEY CITY	S. Taube Inc., 250 Jackson Ave.	HEnd'rs'n 3-2606-0642
JERSEY CITY	Waters Pharmacy, 492 Jackson Ave.	DElaware 3-3043
KEYPORT	Sav-On-Drugs, J. Meisler, opp. Post Office	COlfax 4-0904
LAKEWOOD	Alpert's Pharmacy, 224 Clifton Ave., Cor. 3rd St.	LAkewood 6-0023
LITTLE FALLS	Swisher Pharmacy, Inc., 94 Main St.	CLifford 6-0835
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MORRISVILLE, PA.	Pryor's Pharmacy, Bridge St. & Penna. Ave.	CYpress 5-7416
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MOUNT HOLLY	Mount Holly Pharmacy, 64 Main St.	AMherst 7-0453
NEWARK	Marquier's Pharmacy, Sanford & So. Orange Aves.	ESsex 3-7721
NEWARK	Smith's Pharmacy, 315 So. Orange Ave.	MArket 3-1514
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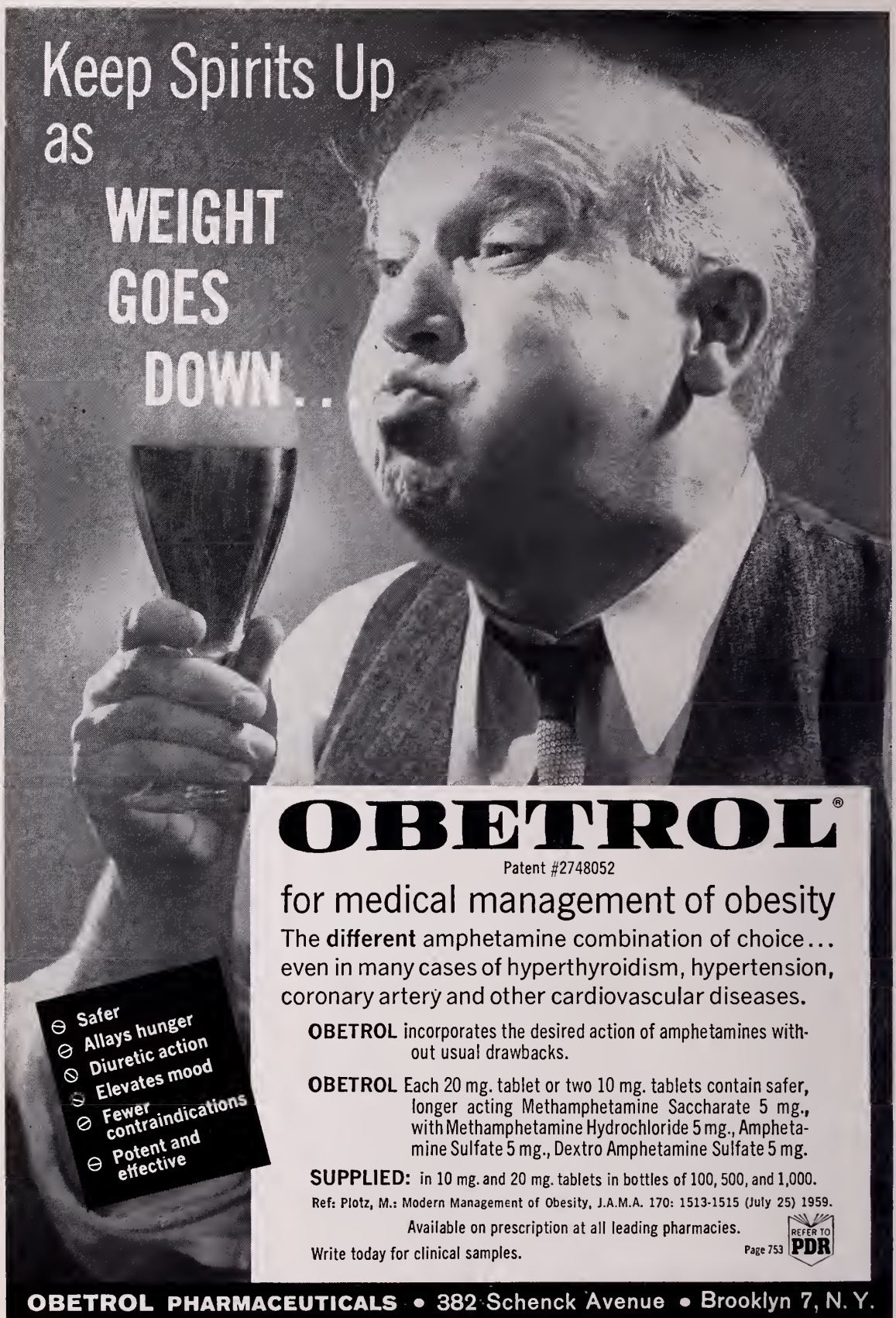
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SOMERDALE	Balaban's Pharmacy, Maiden Lane & White Horse Pike	STerling 3-2956
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SOUTH ORANGE	Taft's Pharmacy, 2 South Orange Ave.	SOuth Orange 2-0063
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TRENTON	Episcopo's Pharmacy, Chambers & Liberty Sts.	EXport 3-3017
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TRENTON	H. S. Hughes, Thatcher Pharmacy, 401 Hudson St.	EXport 2-5616
TRENTON	Kehr's Pharmacy, A. F. Capriotti, R. P., Manager	OWen 5-6807
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VENTNOR	Barsky Drugs, Inc., 5217 Atlantic Ave.	ATlantic City 2-1177
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WEST ORANGE	West Orange Pharmacy, 443 Main St.	ORange 4-9824
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Ref: Plotz, M.: Modern Management of Obesity, J.A.M.A. 170: 1513-1515 (July 25) 1959.

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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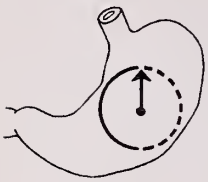
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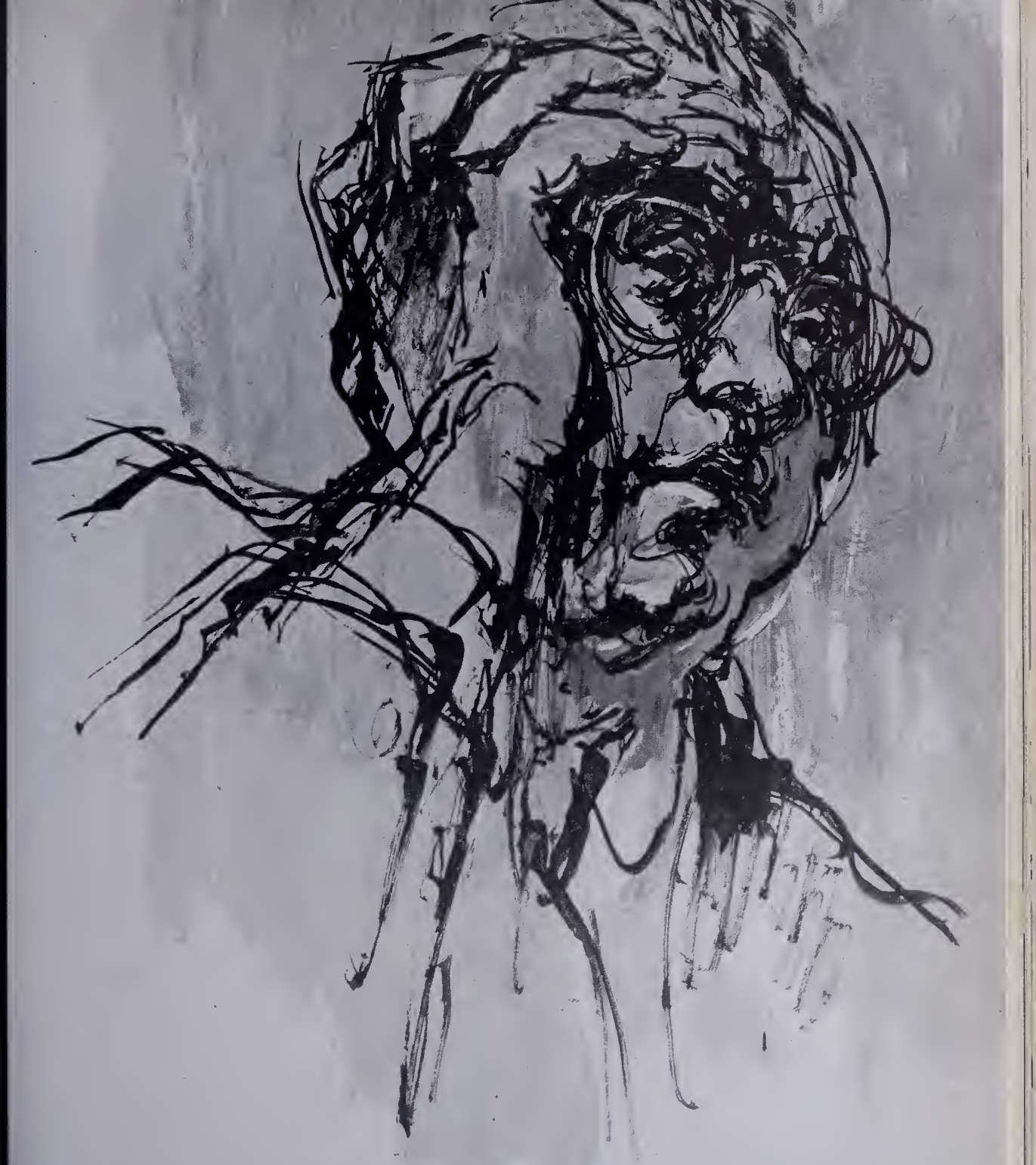
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1. Spoor, H. J.: N. Y. State J. Med. Oct. 15, 1958

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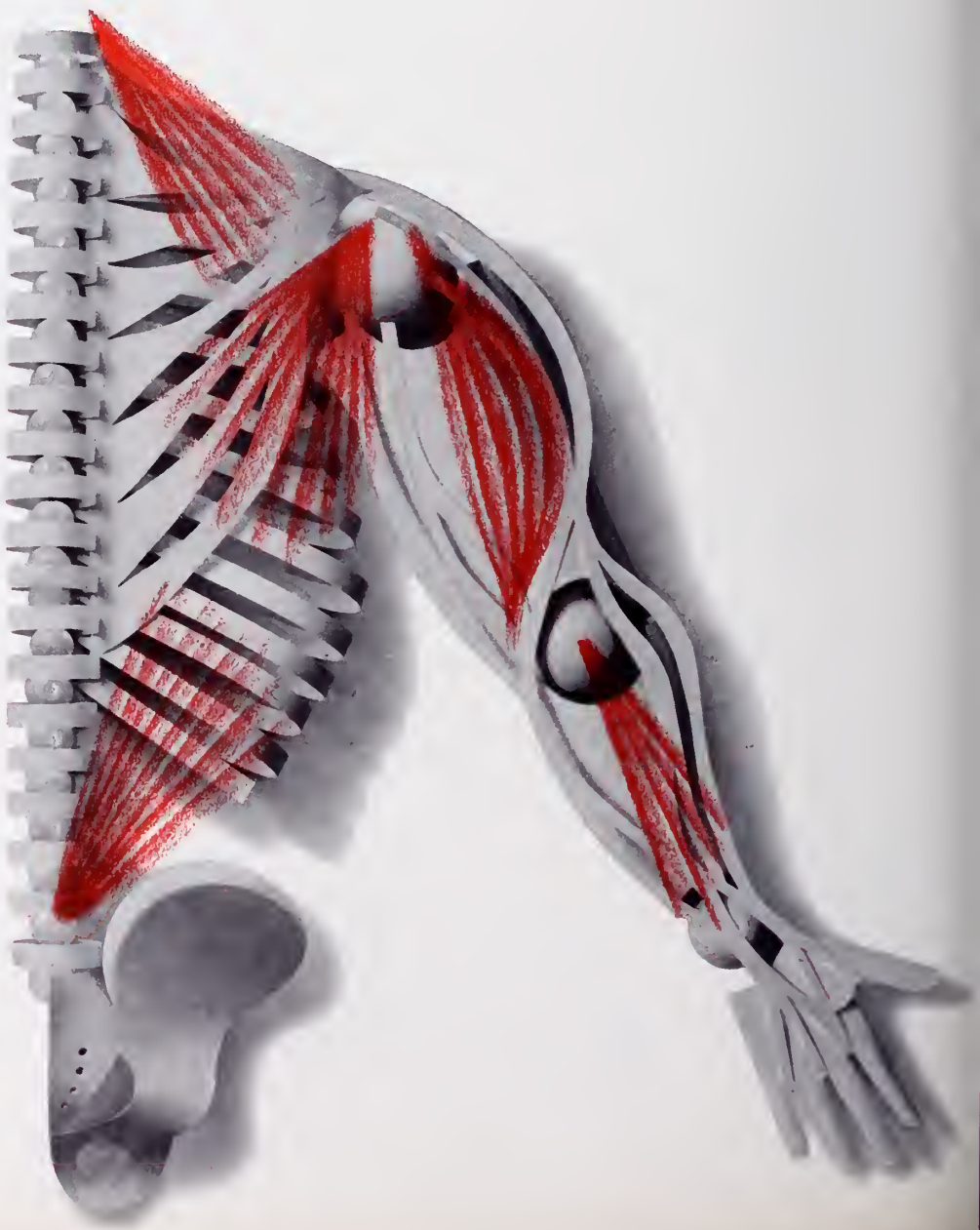
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Kuge, T.: Submitted for publication.

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Wein, A. B.: The Use of Carisoprodol in Orthopedic Surgery and Rehabilitation. Proceedings of the Symposium on The Pharmacology and Clinical Usefulness of Carisoprodol. Wayne State University Press, Detroit, 1959, p. 156.

In a double-blind study, SOMA was reported to be "clinically effective to a highly significant degree." (92 patients.)
Cooper, C. D., and Epstein, J. H.: The Clinical Evaluation of Carisoprodol by a double-blind technique. Ibid. p. 97.

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BIBLIOGRAPHY: 1. Berger, F.M., Kletzkin, M., Ludwig, B.J., Margolin, S. and Powell, L. S.: J. Pharm. Exp. Ther. *127*:66 (Sept.) 1959. 2. Leake, Chauncey D.: Proceedings of the Symposium on The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959, p. 8. 3. Kestler, Otto: Ibid. p. 143. 4. Proctor, Richard C.: Ibid. p. 122. 5. Berger, Frank M., Ibid. p. 25. 6. Goodgold, Joseph, Hohmann, Thomas and Tajima, Toshihiro: Ibid. p. 66. 7. Gamnon, George D. and Tucker, Samuel: Ibid. p. 70. 8. Baird, Henry W. and Menta, Dominic A.: Ibid. p. 85. 9. Cooper, C. David and Epstein, Jerome H.: Ibid. p. 97. 10. Korst, Donald R., Gerard, R. W., Miller, James G., Small, Iver F., Graham, I. J. and Winkelman, Eugene I : Ibid. p. 104. 11. Friedman, Arnold P.: Ibid. p. 115. 12. Trimpi, Howard D.: Ibid. p. 150. 13. Wein, Arthur B.: Ibid. p. 156. 14. Olds, James and Travis, R. P.: Ibid. p. 39. 15. Hess, Eckhard H., Polt, James M. and Goodwin, Elizabeth: Ibid. p. 51. 16. Phelps, Winthrop M.: Ibid. p. 131. 17. Spears, Catherine E.: Ibid. p. 138. 18. Ilyde, L. P. and Hough, Charles E.: Ibid. p. 166. 19. Spears, Catherine E. and Phelps, Winthrop M.: Arch Pediat., *76*:287 (July) 1959. 20. Phelps, Winthrop M.: Arch. Pediat., *76*:243 (June) 1959. 21. Friedman, Arnold P.: Paper presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 22. Frankel, Kalman: Ibid. 23. Fransway, Robert L.: Ibid. 24. Kuge, T.: Unpublished reports.

Literature and samples on request WALLACE LABORATORIES, New Brunswick, New Jersey

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1. Smith, I. M., and Soderstrom, W. H.: J. A. M. A., *170*:184 (May 9), 1959.

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Editorials • • •

Profile in the Mirror

A recent issue of *Pageant Magazine* offers a profile of the successful physician. His shirt looks rumpled, he marries late, he has two children close together, he listens abstractly to a patient's recital of symptoms, he is motivated by a desire to prove something—more to his professional brethren than to his patients—he talks too much, he prefers the company of other doctors, and tends to pontificate when in a group of laymen; he is irritatingly indifferent to community affairs and he is bewildered at the task of changing an electric light bulb.

Well, there *are* easier ways of making a living. No one is motivated to enter medical school by the expectation of making a million. The same energy and talents, devoted to business will get that million quicker and easier. So perhaps the medical candidate does have to prove something—to his family anyway.

Medicine is distracting. It is hard to flee from the tyranny of the phone. In fact, technology has fashioned new chains for us—telephone paging systems, short wave radios in our cars, answering services . . . no escape. So perhaps the air of distraction is natural. Concentration on a man's insides makes one careless about his outsides—hence the rumpled shirt. The late marriage? That used to be true, but today so many medical students marry that this figure will soon change. The preference for the company of the brotherhood? This is also true of musicians, steamfitters and sailors. And awkwardness at changing an electric light bulb? That's just a canard, as phoney as a TV quiz program.

In fact, we suspect the whole profile is phoney. There are as many types of physicians as there are of other people. We are of all heights, weights, colors, I.Q.s and sexes—or at least, of *both* sexes. We include egg-heads

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and anti-intellectuals, dowds and dudes, introverts and extroverts, guys and dolls, gladhanders, misers, stuffed shirts, angels, libertarians, humanitarians, and samples of nearly all other types in the human comedy. We have less than our share of jail-birds and more than our share of substantial citizens. We are under-represented among alcoholics, divorces, and idiots and exceed our quota of home owners, bank depositors, and insurance policy holders.

We represent all shades of political opinion. There is no "doctors' vote" and no one could deliver it if there were. We run the gamut of religion from compulsive piety through indifferent agnosticism to bellicose atheism. We include stamp collectors, bibliophiles, private plane pilots, cello players, and big game hunters. Some of us love baseball, some love dice, some love hi-fi music and some love poker. We are the products of every layer of American and foreign society. We were tailor-made at six dozen American medical schools and countless foreign ones—some run by Government, some by churches, some by privately endowed bodies.

Thanks for the effort, *Pageant,* but the subject won't stay still long enough to have his picture taken.

Salute to the Tin Can

Jokesmiths have long used the tin can as the symbol of the indifferent housewife. And Ilya Ehrenburg, a Soviet writer, once derogated us by sneering that "America is a tin can civilization." The indictment is true in a sense, because we do open some 40 billion cans a year. But the handy tin can is no proof of decadence. The much maligned can has improved our health, our wealth and our way of life. Since the "tin can" was patented just 150 years ago this month, this seems to be a good time to remind ourselves of its contribution to our culture. Nicholas Appert perfected the process of sealing food into glass jars after partial cooking, back in 1810, and obtained a French patent on this method. Peter Durand that year, showed that tin-coated metal cylinders did the job even better. So for a century and a half we have had cans—first for food, now for a hundred other items.

The lowly tin can made possible the westward movement of our pioneers. In their covered wagons they took canned meat, fruit and milk. Soldiers in the Civil War and in all our wars since have had canned food and canned water available as field rations—and in spite of all the jests about them, war would have been even more hellish without them. In World War II, tin cans carried not only food but also water, ammunition, and blood plasma. They even learned how to take motorcycles apart and parachute the parts in cans to some of our commandos!

Look at the rows upon rows of canned items on our supermarket shelves. They are the very symbols of abundance, the tools of the good life that has made America the envy of the world. Commercial canning has done more for freeing the energies and time of the housewife than any single invention.

In our kind of civilization, most people do not know how to grow food. Without canning, there would have been widespread malnutrition not to say famine. Does this sound overdramatized? Consider then, how long any of our cities would survive without an uninterrupted supply of processed foods. And to maintain health, the processing must be such as to retain the nutrient value of the food.

So the can now carries tennis balls, shaving cream, Geiger counters, beer, books, bread, blood, bone-grafts, bandages, furniture polish, tooth paste, detergents, eye grafts, and water as well as food. Pretty good for a little cylinder of tin-coated metal!

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Q-Fever in New Jersey:*

Clinical and Epidemiologic Investigation of a Case With Some Unusual Manifestations.

Q-Fever is generally thought of as a disease from the other side of the world. Now, for the first time in history, a case is reported in New Jersey. There have undoubtedly been earlier cases —but the clinicians dismissed them as "fever of unknown origin."

Q-FEVER[1] was first described in 1937 in Australia.[2] Since then its world-wide distribution in farm and domestic animals and in man has been recognized.[3,4,5] In the last 15 years its clinical and epidemiologic importance in the United States has been emphasized by an increasing number of reports of human and animal infections in many states.[6-10] The variable clinical picture of Q-Fever and its salient epidemiologic features should be better known to clinicians. It is undoubtedly more widespread in distribution than presently suspected. It may be a significant cause of morbidity. Fortunately effective treatment is available. If the possibility of Q-Fever is considered more frequently, the nature of some fevers of "undetermined origin" may be clarified and a better understanding of the range of Q-Fever manifestations will be achieved.

This report is concerned with the first diagnosed case of Q-Fever in New Jersey supported by laboratory isolation of the organism. The patient studied exhibited a somewhat atypical clinical syndrome following both the ingestion of unpasteurized milk and contact with newborn calves. The responsible organism was isolated from the animals with which the patient had associated, and an epidemiologic study was conducted.

EPIDEMIOLOGIC FEATURES

THE causative organism, coxiella burnetii, was first studied and identified by Burnet[1] of Queensland (Australia) in 1935 and later described by Derrick[2] in 1937. It is related to, though somewhat distinct from, the true rickettsiae in that it is filtrable[11] and demonstrates greater resistance to physical and

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chemical agents. Animals such as cattle, sheep, and goats may serve as an asymptomatic reservoir of infection. Identification is therefore possible, by serologic testing with the capillary agglutination test,[12] by complement fixation or by isolation of the organism from milk or from tissue such as placental membranes of infected animals.

In cattle infected during pregnancy the organism is shed in great numbers during the last month of gestation and the first month of the postpartum period. Dairy cows [13] contaminate the environment grossly by postparturient passage of highly infected placental membranes. Luoto [13] found that 45 per cent of serologically positive lactating cows shed organisms in their milk. In these animals the agent may be isolated from the gravid uterus or the lactating mammary gland. Studies at the University of California revealed that milk found to be highly infectious in the raw state was rendered non-infectious by high-temperature, short-time pasteurization. Pasteurization by the vat method required temperatures of 145 degrees F. for 30 minutes instead of the usual 143 degree F. in order to effect destruction of C. burnetii.[14]

Many theories have been advanced as to the mode of transmission of Q-Fever to man. Prevailing opinion in this country is that inhalation of infected dust or droplets is the most likely avenue of infection.[15] Q-Fever may be an occupational disorder in laboratory workers,[16] abattoir employees, or those living in close proximity or exposed in other ways to cattle,[17] sheep, or goats.[18]

Early and extensive studies of the epidemiology of Q-Fever were conducted in California.[13,17-20] In Artesia, where dairy cows are extensively raised, Dr. F. W. Young, a practicing physician, noted outbreaks of fever in his patients following "Santa Ana" windstorms. Positive sera for Q-Fever were found in eight patients.[7] A follow-up survey by the United States Public Health Service indicated that Q-Fever was endemic in the area. Cases of virus pneumonia were then investigated. 17 patients were found who exhibited positive titers for Q-Fever, ranging from 1:64 to 1:512. Fifteen of these seventeen lived near dairies. Sera from dairy cattle in the area were tested and 16 per cent were found positive for Q-Fever. A study of outbreaks of Q Fever at abattoirs in Chicago, Illinois, and Amarillo, Texas, where sheep and cattle were being killed, indicated that attack rates in humans were 68 to 79 per cent higher among those actually engaged in the killing of animals and the handling of the carcasses than those in less direct contact with infected animals. This was especially true where exposure to splatter material was great.[8]

The rapid movement of dairy cattle, *e.g.*, import and export for the purpose of cattle shows, introduces Q-Fever in areas previously considered free of infection. This was demonstrated in Ohio.[9] States wherein the disease is prevalent may contribute to its spread through the exportation of a large number of cattle, as shown in Wisconsin.[10]

A 35-year old woman was admitted to the Hunterdon Medical Center in Flemington, N. J., with stomatitis, gingivitis, and fever. Six days before admission she had become aware of sorenss in the inside of her mouth and pain on swallowing. This had been followed within 24 hours by swelling of the lymph nodes in her neck. Her family physician noted redness of the pharynx. He treated her with penicillin and Gantrisin®. She had had a temperature of 101 when first seen by her physician, and she continued fever of this degree up to the time of her admission. Dull frontal headache was present from the onset of her illness. The stomatitis became steadily worse, the gums became swollen and tender, and cervical lymphadenopathy was marked. Additional treatment instituted by her family physician included hexa-vitamin capsules, Meticorten®, vitamin C, and (for 24 hours before admission) Aureomycin® in unspecified amounts. Symptoms became more pronounced prior to admission. Throughout the illness she experienced malaise, chilliness, and some anorexia.

Her past history was not pertinent except for congenital glaucoma in the left eye.

Physical Findings. She was a moderately obese (193 pound) woman in considerable distress because of soreness of her tongue, mouth, and gums. She complained bitterly of difficulty in swallowing even fluids. Major clinical findings were limited to the oropharynx. The gingivae were edematous, swollen, and angry-red. There were many lentil-sized white papular lesions, scattered over the gums, inner aspects of the buccal mucosa, fauces, posterior pharynx and tongue. Slight ulcerations were noted along the gingival margins of the teeth and on the inner aspects of the buccal mucosa of both lips. She had bilateral tender anterior cervical lymphadenopathy. No axillary, supraclavicular, or inguinal nodes were felt. She had no skin lesions and the spleen was not felt. Examination of the heart, lungs, and nervous system revealed no abnormalities.

Laboratory Data. At the time of admission, hemoglobin was 14.7 Grams; the white blood count 7,300 with 47 per cent segmented polymorphonuclear leukocytes, 19 per cent nonsegmented poly-

morphonuclear leukocytes, 27 per cent lymphocytes, 6 per cent monocytes, and 1 per cent eosinophiles. A repeat blood count showed 47 per cent lymphocytes with a hematocrit of 47 per cent. The erythrocyte sedimentation rate was 33 millimeters per hour (Wintrobe). Later laboratory tests indicated 40 per cent lymphocytes, 9 per cent eosinophiles, and hematocrit 45 per cent. Nose and throat cultures revealed a mixture of D. pneumoniae and N. catarrhalis. Blood urea nitrogen was 12.0, and the fasting blood sugar was 78 mg. Heterophile antibody titer was normal.

The complement fixation titer for Q-Fever was 1:256. A blood sample obtained more than one year after the symptoms subsided, revealed an antibody titer of 1:4. Negative complement fixation examinations were obtained for the following: influenza A and B, psittacosis, lymphogranuloma venereum, adeno-virus, and Coxsackie virus. Agglutination titers for typhoid, paratyphoid, and Brucella were not significant.

Course: Her temperature on admission was 101 and rose to 102 shortly thereafter. It remained between 100 and 101 for four days, dropping on the fifth day. She received 250 milligrams of tetracycline four times a day and with alkaline mouth washes when needed. Symptoms gradually disappeared with gradual subsidence of lymphadenopathy, increase in appetite, and a sense of well-being.

She was discharged after one week in the hospital and was seen in the out-patient department a fortnight later. At that time there were a few small, white, papular areas still on the gums. The cervical lymph nodes had returned to almost normal size and had lost their tenderness. All other symptoms had disappeared. She had recorded her temperature at home in the intervening period. The highest (by mouth) was 99.6.

Oropharyngeal smears were obtained at the time of her admission, and subsequently, to determine the presence of Vincent's organism. These were all negative. Smears and cultures of the buccal mucosa for fungi were also negative.

Complement fixation titers for Q-Fever, American strain, 9 mile, were obtained on the patient's three children. These were 1:4 or less in each child.

EPIDEMIOLOGIC INVESTIGATION

A POSITIVE blood serologic test for Q-Fever on the above patient was reported to the New Jersey State Department of Health by both the University of Pennsylvania Virus Diagnostic Laboratory† and the Hunterdon Medical Center in Flemington, N. J. During the time of this investigation, the patient was at home in a rural, upland, wooded section of Warren County (Mansfield Township) in the northwest corner of New Jersey.

Primary investigation revealed that the patient had consumed raw milk from animals on a neighboring farm a half mile away. She also had had contact with dairy cattle and their newborn young on that farm, often fondling the newborn. Her last contact with these animals had been two weeks prior to her illness. She told the investigator that she liked to eat raw meat, particularly beef.

Blood samples were obtained from three goats on the patient's premises. All proved to be negative by the complement fixation test.

Six months later, in conjunction with the Brucella blood testing program conducted by the New Jersey State Department of Agriculture, blood samples were obtained from 55 dairy cows on the neighboring dairy farm. The serum was divided and specimens forwarded to the New Jersey State Department of Health Laboratory for Q-Fever determination. Analysis indicated 14 per cent infection in the herd. A month later, a blood test showed 30 per cent infection. Ten months later the figure was 34 per cent. A year after the patient's discharge, milk samples from a neighboring farm showed a positive titer of 23 per cent. Seven months later, 50 per cent of the milk samples from this herd were positive. See table below. A titer of 1:8 or higher is considered positive.

BLOOD AND MILK SPECIMENS POSITIVE FOR Q-FEVER

Specimen	Date of Collection	Number of Specimens	Number Positive*	Per Cent Positive
Blood	12-11-57	55	8	14.5
Blood	1-11-58	56	17	30.1
Blood	10-16-58	44	15	34.2
Milk	6- 2-58	34	9	23.5
Milk	2- 3-59	40	20	50.0

*Positive indicates a titer of 1:8 or above.

At the time the patient's case was diagnosed (June 1957), milk from this herd was being shipped to a local pasteurizing plant where twelve persons were engaged in processing raw milk. Blood specimens from each of these person as well as from the farmer and three members of his family gave insignificant titers for Q-Fever.

†Dr. Klaus Hummeler at the University of Penna. Diagnostic Laboratory.

DISCUSSION

GENERALLY, the major symptoms reported for Q-Fever have been those of a febrile process with severe headache and malaise, but with a paucity of physical findings. A number of other widespread complications have also been described, involving most major organ systems. The clinical manifestations described by Derrick [2] were those of fever, generalized malaise, headache, and bradycardia. Huebner [19] and his colleagues, and Denlinger [20] have shown that the clinical manifestations may involve many organ systems. These and other studies[23] particularly emphasize the high incidence of pulmonary infiltration which occurred in from 60 to 80 per cent of the cases. More recently, aseptic meningitis [21] and a lymphoma-like syndrome [22] have been added to the list of manifestations. Several observers [4,23] have suggested that many mild or atypical cases are not recognized and that the full range of clinical features is yet to be described more completely.

The clinical picture of Q-Fever is nonspecific. This disease should be considered more frequently when a patient presents a syndrome resembling influenza, Brucellosis, atypical pneumonia, or aseptic meningitis, even in areas where the disease is not known to be present. Specific diagnosis can be made only by isolation of the organism from patients, or more commonly by a rise of specific serum antibodies during the course of the acute illness, and the fall of titer during the convalescence and recovery period.[19 20,23] Mortality is generally low,[4,19] and morbidity is self-limited, though there may be relapses and even chronic symptoms.

THE case described here exhibited some unusual manifestations, not heretofore related to Q-Fever. This patient experienced the expected symptoms of fever, malaise, chilliness, and headache. There was no evidence of pulmonary infiltration. The observed symptoms were those of stomatitis, gingivitis, and cervical lymphadenopathy. The peripheral blood picture was essentially normal except for relative lymphocytosis. We were not able to find reference to these observed symptoms in any of the extensive reports on the clinical aspects of Q-Fever. In the review by Huebner and his colleagues [19] of 625 cases, relative lymphocytosis was observed, but lymphadenopathy was not reported. There was no reference to gingivitis or stomatitis. Denlinger [20] reported that 10 of his 80 cases showed small, non-tender anterior cervical nodes, but he did not find any apparent relationship to the disease process. No comment was made on follow-up of these nodes during the convalescent period. Denlinger also noted an incidental tendency to lymphocytopenia rather than lymphocytosis.

Ramos, Hodges, and Maroney [22] recently reported a 19-year old boy who had symptoms of remittent fever, anemia, lymphocytosis, axillary adenopathy, and splenogaly as well as a pulmonary lesion. Bone marrow examination showed increased reticulum cells. Lymphoma was suspected. The patient underwent spontaneous remission without the use of antibiotics, and he showed a rising Q-Fever complement fixation titer during the course of his illness.

The patient in the present study had been ill for ten days before being admitted to the hospital and had *not* responded to penicillin, Gantrisin®, and Aureomycin®. Her specific antibody titer for Q-Fever had been 1:256 during the course of the acute illness and had subsided to 1:4 one year later. The rise in titer was not as high as had been reported [20] in many cases, but was well above the minimum.[23] Aureomycin® which is known to be effective against this disease was given in unstated amounts before admission and may have modified the antibody response. The only other human disease to give a positive reaction to the Q-Fever complement fixation test is Rocky Mountain Spotted Fever. In this situation, however, Huebner and colleagues [19] state that the titer does not rise above 1:32.

The exact mode of transmission of infection in the present study is not clear. She did drink unpasteurized milk from cows shown to be infected, but the other members of her family who also consumed the raw milk did not exhibit clinical symptoms nor any elevation of complement fixation titers for Q-Fever. Since the patient also fondled the newborn calves and frequented the barn, it is not un-

likely that the mode of transmission was related to these contacts.

In previous studies,[4] cows, sheep, goats, bandicoots, and 17 species of ticks have been shown to be reservoirs of infection. Most human cases have been related to direct or indirect contact with farm animals. Transmission of the organism by inhalation of droplets or infected dust is considered to be most common. Other modes of transmission such as by direct contact with infected carcasses or by the ingestion of infected unpasteurized milk cannot be overlooked.[4,8,18,24] The contact with infected animals may be quite indirect. One-third of Denlinger's 80 cases [20] denied direct exposure, but did live in the general vicinity of infected herds. Luoto [6] emphasizes the heavy contamination of the environment which occurs at the time of parturition of infected animals. Others [25] have demonstrated a parallel between the incidence in humans and the occurrence of lambing.

IN THIS investigation, nine of the 34 milk samples submitted to the Rocky Mountain Laboratory, U. S. Public Health Service, Hamilton, Montana, were found positive on Capillary Tube Agglutination (CTA) and, subsequently, also found positive on isolation through guinea pig inoculation. Therefore, the clinician should think of this disease even if the patient has had no known contact with infected animals. Surveys [25] of cows conducted serologically in six states showed infection to be present so the potential reservoir for human infection is large and widely distributed.

The first known human case occurring in the East was reported in 1949 in Pennsylvania by Janton, Bondi, and Sigel.[27] Other cases reported in the East included an outbreak in 1950 in workers handling guinea pig carcasses in Syracuse, N. Y. Nine of these workers were hospitalized and positive serological titers were found in thirty-five others.[24]

The present report is *the first confirmed case of Q-Fever in a herd in New Jersey and should* alert clinicians to the possibility of this disease in Northeastern United States. Q-Fever should be considered in the differential diagnoses of fevers of obscure origin even when contact with animals is quite indirect. There are probably many unrecognized milder variations of the Q-Fever syndrome. As clinicians become alerted to the possibility, further cases will probably be recognized. When there is a high incidence of patients with pulmonary infiltration, the cases with "atypical" or "viral" pneumonia syndromes should be studied and complement fixation tests initiated. Wider application of serologic tests in suspected clinical situations will uncover subclinical and atypical variants of this disease.

The more versatile antibiotics usually provide satisfactory clinical treatment for Coxiella burnetii infections. This organism (in contrast to other rickettsiae) is relatively insensitive to erythromycetin, chloramphenicol and thiocymatin. Of the more versatile antibiotics, Aureomycin® and Terramycin® are the most effective.[23,28,29] Denlinger[20] reported that in his large series, streptomycin, para-amino-benzoic acid and sulfonamides were all ineffective.

The patient in this study responded to use of Achromycin.® Though, in most instances, the disease is self-limited, treatment with Terramycin® or Aureomycin® should be instituted to ameliorate symptoms and prevent relapse.

SUMMARY

HERD and human infection with Coxiella burnetii is reported for the first time in New Jersey. The variability of the clinical syndrome is emphasized. Stomatitis, gingivitis, and cervical adenopathy are now added to the known manifestations of the disease. The organism was isolated from milk produced by the same herd with which the patient had had contact either directly or by consumption of raw milk. Through blood testing, serologic evidence of infection was also obtained. An increasingly higher incidence of infection was noted in this dairy herd studied from the initiation of the epidemiologic investigation in 1957 until early 1959.

Q-Fever is becoming more widespread in the United States. It should be considered in the differential diagnoses of fevers of obscure

origin, in patients with the syndrome of "atypical" pneumonia, and in patients with aseptic meningitis. Awareness of subclinical and atypical manifestations will result in greater recognition of Q-Fever, a disease which is increasing in public health and clinical importance.

The writers acknowledge the assistance and consultations of Dr. Lauri Luoto, Senior Veterinarian, Rocky Mountain Laboratory, Department of Health, Education, and Welfare, Hamilton, Montana; and the following members of the New Jersey State Department of Health: Miss Lillian Bajda, District Consultant, Community Health Organization, Northern State Health District; Mrs. Eleanor Thomas, Chief Serologist, and Mr. Anthony Lucci, Senior Serologist, Division of Laboratories. Acknowledgment is also made to Dr. Klaus Hummeler of the University of Pennsylvania Laboratory.

Note: Most doctors were taught that the "Q" in Q-Fever stands for Queensland, the Australian State from which it was first reported. Our Society Archivist, Dr. Fred B. Rogers, however, tells us that the "Q" actually stands for "Query" to emphasize the uncertainty of the etiology.—*Editor*

Department of Health, Trenton 25, N. J.

A list of 29 citations to the literature appears in the authors' reprints.

Speakers Available on Nutritional Problems

The National Vitamin Council jointly with the Philadelphia County Medical Society are sponsoring speakers for meetings of county medical societies and hospital staffs in New Jersey. The speakers will discuss practical aspects of nutrition and metabolism as they affect medical and surgical problems.

The speakers are clinicians in the field of nutrition and metabolism. Their talks integrate recent advances in nutrition and metabolism with bed-side medicine.

Would you like one or more of these authorities for your county medical or hospital staff meeting? If so, write to Dr. Michael Wohl, Committee on Nutrition, County Medical Society, 1727 Pine St., Philadelphia 3, Pa. Here is the panel:

D. B. Coursin, M.D., *nutritional problems of infancy and of the adolescent;* Garfield G. Duncan, M.D., *diet in the management of diabetes;* Paul Gyorgy, M.D., *nutrition with reference to the newborn and premature; deficiency anemia in infants;* Robert W. Hillman. M.D., *pregnancy; liver disease; geriatrics;* Willard A. Krehl, M.D., *nutrition and skin disease; peptic ulcer and ulcerative colitis;* John F. Mueller, M.D., *diet in coronary artery disease; hypertension, anemias and obesity;* Harold M. Nitkowsky, M.D., *the malnutrition syndrome;* Robert E. Olson, M.D., *atherosclerosis; alcoholism; deficiency disease and obesity;* Herbert Pollack, M.D., *the general topics related to therapeutic nutrition;* Elaine Ralli, M.D., *nutrition in diabetes;* Robert G. Ravdin, M.D., *nutritional problems associated with surgery; the metabolic response to trauma;* Edward H. Reisner, Jr., M.D., *folic acid in relationship to blood formation;* Seymour H. Rinzler, M.D., *diet and coronary artery disease;* William H. Sebrell, Jr., M.D., *vitamins in medical practice; nutrition in alcoholism;* Maurice E. Shils, M.D., *nutritional management of malignant conditions; nutrition in renal disease;* Richard W. Vilter, M.D., *nutrition and cardiovascular disease; the place of the less well-known B complex in medical practice;* C. Wilmer Wirts, M.D., *nutritional aspects of sprue syndrome, pancreatic insufficiency* and *post gastrectomy steatorrhea;* Harold A. Zintel, M.D., *nutrition in surgery; fluid and electrolytes; nutrition in burns.*

The New Jersey county medical society or hospital staff will not be asked to assume any expense incident to the selection of any of these speakers.

John N. Pannullo, M.D.

Daniel M. Cerone, M.D.

Newark

Promethazine in Obstetrics*

Trial on 600 patients has satisfied these authors that promethazine hydrochloride is the choice pre-anesthetic tranquilizer in obstetrics. The drug was found to allay anxiety, potentiate analgesia and reduce apprehension. There were no bad results, no side-effects and no neonatal deaths.

Rarely is a woman subjected to greater stress than during pregnancy. Stress exists, not only for the entire duration of pregnancy, but during the postpartum period as well. Unfortunately, some major and most minor disturbances, such as constipation, fatigue, nausea and vomiting during pregnancy have been considered "normal." True, they do occur in the average patient; but this does not imply that they are normal, necessary or desirable. The same reasoning holds true for pain in childbirth. At one time, the control of pain was not considered necessary; today the control of pain during childbirth ranks high among the duties of the obstetrician.[1]

Since 1845, when ether was first used in obstetrics,[2] numerous technics have been developed in an effort to control pain and still provide the patient with the necessary safety for herself and her child.

The purpose in prescribing pre-anesthetic medication in obstetrics is two-fold: (1) to diminish anxiety, apprehension, and fear; and (2) to control pain, and prepare the way for the use of a general anesthetic. Regardless of the technic used, the end result should have an over-all beneficial effect on the patient without producing untoward effect on the newborn infant. Although there are 68 methods[3] presently in use to control pain, few provide even half the desired relief.

Of the many pharmaceutical agents introduced to control pre-anesthetic stress, none has provided the usual tranquility without altering vital functions. The use of narcotic analgesics, such as morphine sulfate, other opium alkaloids, and meperidine, in obstetrics requires considerable experience to avoid complications. The opiates are respiratory depressants, especially of the fetus, and may result in asphyxia. For this reason, the amounts permissible for use in obstetrics are seriously limited. This also is true of scopolamine. Although small amounts of scopolamine are beneficial in producing sedation, an increase in the amount administered (or repeated doses) frequently results in excitement, disorientation, and restlessness.[4] Barbiturates usually have a sedative effect but, in instances in which anxiety and tension already exist, they cause excitement by releasing the inhibitory control of the patient.[5]

Not one of these agents, when used alone

*From the Martland Medical Center (Newark) and the Newark Presbyterian Hospital.

1. Javert, C. T. and Hardy, J. D.: *Anesthesiology*. 12:189 (1951).
2. Sollmann, T.: A Manual of Pharmacology. Philadelphia. 1957. Saunders. Ed. 8, page 880.
3. Lull, C. B. and Kimbrough, R. A.: Clinical Obstetrics. Philadelphia 1953. Lippincott.
4. Sollmann, T.: *op cit.*
5. Drill, V. A.: Pharmacology in Medicine. New York 1958. McGraw-Hill.

and in amounts permissible for the safety of the patient and fetus, is capable of entirely eliminating the intensity of obstetric pain and producing the quiescence desired.

Combinations of these pharmaceutical agents have been used to produce obstetrical analgesia and vary according to the individual physician. Many combinations have produced good results. But they do not approach the ideal because of the concomitant occurrence of nausea, emesis, and respiratory and vascular depression, with the resulting depressant effect on the fetus.

PROMETHAZINE

As is the aim of every obstetrician, we desired to minimize, if possible, the derangement of normal physiologic processes in our parturient patients. The recently reported uses of promethazine† (a derivative of phenothiazine) in the antepartum regimen of obstetrical patients led us to inquire further into its possible application in our practice.

According to the results obtained by other investigators, promethazine has a potent sedative action; enhances the actions of analgesics and anesthetics, thereby making it possible to reduce the amount of medication required; has excellent antiemetic properties; is without severe hypotensive or respiratory effects on the mother and the infant; shortens the period of labor; and does not alter renal hemodynamics significantly (increases slightly the excretion of water but does not increase sodium excretion).[6-10]

Because of the excellent results and few side effects observed by other investigators, promethazine hydrochloride† was administered to more than 500 private and ward patients included in our investigation.

INITIAL STUDY

One hundred parturient patients were included in the initial study; 50 primiparous patients ranging in age from 15 to 37 years (average age, 19 years), and 50 multiparous patients ranging in age from 17 to 38 years (average age, 25 years). Gravidity ranged from i to x; parity from o to vii.

Prior to the administration of medication, the emotional tension of the patients was classified as severe, moderate, or mild. In the majority of cases, the emotional tension was classified as moderate; the remaining cases resulted in an approximately even distribution between severe and mild.

Medication was administered, intramuscularly, to the primiparous and multiparous groups when the cervix had become dilated to approximately 3 centimeters.

The initial medication for the primiparous group included 50 milligrams of promethazine hydrochloride† used in combination with morphine sulfate, grains 1/6 for 48 patients; with morphine sulphate, ¼ for two patients.

For the multiparous group, the initial medication included 50 milligrams of promethazine hydrochloride† used in combination with morphine sulfate, grains 1/6 for 43 patients; morphine sulfate, grains 1/6 and grains 1/200 of scopolamine for two; with morphine sulfate, grains 1/6, and secobarbital grains 1½ for one and with 50 milligrams of meperidine and phenobarbital grains ½ for one. Three patients received promethazine hydrochloride† without other medication.

Seven patients in the primiparous group were given additional medication. In five of these, the initial dose was repeated. One of the remaining two patients received morphine sulfate, grains 1/6 (the amount initially given in combination with 50 milligrams of promethazine†). The other patient received 50 milligrams of promethazine,† intravenously, and three hours later received another 50 milligrams intramuscularly. For only one patient

†Under the trade-name Phenergan®, promethazine is available from Wyeth Laboratories, Inc. of Philadelphia.

6. Sadove, M. S.: Journal of the American Medical Association, 162:712 (1956).

7. Moyer, J. H., *et al.*: Antibiotic Med. & Clin. Therapy, 4:613 (1957).

8. Light, G. A., *et al.*: Journal of the American Medical Association, 164:1648 (1957).

9. Fitzgerald, W. J., *et al.*: New York State J. Med., 58:1514 (1958).

10. Adelman, M. H., *et al.*: Anesthesiology, 19:93 (1958).

in the multiparous group was the initial dose of medication repeated (promethazine† and morphine sulfate).

Thirty per cent of the patients required anesthesia for delivery. In the primiparous group, 20 patients (40 per cent) were given anesthesia: saddle block, 16 patients; pudendal block, three patients; ether, one patient. In the multiparous group, 10 patients (20 per cent) were given anesthesia: saddle block, four patients; pudendal block, three patients; trichloroethylene and a local anesthetic, one patient; trichloroethylene, one patient.

RESULTS OF INITIAL STUDY

THE response to medication was excellent in 16 per cent, good in 55 per cent, and poor in 18 per cent. In the remaining 11 per cent, it was impossible to determine the effectiveness of medication as the period of time between administration and delivery was insufficient to permit accurate evaluation.

Apprehension and anxiety were markedly reduced in the majority of patients. Most were quiet, relaxed, and cooperative; sleeping or resting comfortably between contractions.

The duration of labor was somewhat reduced for both the primiparous and multiparous groups. For the primiparous patients, the duration of labor varied from 4 hours and 33 minutes to 31 hours and 33 minutes; the average duration of labor for this group was 15 hours. For the multiparous patients, the duration of labor varied from 2 hours and 20 minutes to 20 hours and 56 minutes; average duration of labor was 10 hours.

The anesthesiologists said that those patients who received promethazine† were calm, took the anesthetic without struggling, and appeared to require less to obtain the desired level of anesthesia.

In not one instance, was there a precipitous decrease in blood pressure of the patient as a result of medication. Delivery was either spontaneous or required the application of low or mid forceps. Cesarean section was not needed for any of the patients. There was a marked reduction in the incidence of post-anesthetic nausea and vomiting. Most of the patients were completely relaxed during the postpartum period. Changes in blood pressure, pulse or respiratory rates did not occur. There were no maternal deaths. Minimal side effects including drowsiness, dizziness and dry mouth were noted by five patients.

No untoward effect on fetal heart rates attributable to the medication was noted. Of 100 infants delivered, 96 (including 2 of 3 premature infants) cried immediately or within 30 to 60 seconds after delivery. There were no fetal or neonatal deaths. However, there was some fetal distress. Four infants required oxygen and resuscitation—one as a result of complications during delivery (ROT presentation without rotation—as head passed ischial spines, head rotated to ROA); one as a result of hard labor; one as a result of prematurity. One showed mild cyanosis, the cause of which was not determined.

SUPPLEMENTARY STUDIES

THE good results and absence of harmful side effects in the initial study led to the administration of promethazine hydrochloride† to over 600 additional patients.

Fifty milligrams of promethazine hydrochloride† were given alone and in combination with morphine sulfate, grains 1/6, opium alkaloids, grains 1/3, scopolamine, grains 1/200; or meperidine hydrochloride, 50 milligrams intramuscularly. In some instances, the patients received only promethazine hydrochloride†, 25 milligrams intravenously.

As in the initial study, the medication was first given when the cervix was dilated to approximately 3 centimeters. Doses of morphine sulfate, opium alkaloids, meperidine, or scopolamine in combination with 50 milligrams of promethazine† were repeated on an average of every four hours for those patients who required more than the initial dose of medication. Some patients required 4 doses.

AGGREGATE RESULTS

With few exceptions, the results in the 600 cases were consistent with those in the initial study.

In ten patients, labor appeared to be decelerated. Those patients who received opium alkaloids, and promethazine hydrochloride,† intramuscularly, slept. The effect lasted from 3 to 4 hours and the medication usually was repeated two or three times. Two patients did not experience adequate sedation or analgesia. The remaining patients were drowsy, relaxed, and serene, but did not sleep.

CONCLUSIONS

Promethazine hydrochloride,† used alone or in combination with morphine sulfate, opium alkaloids, or meperidine, with or without scopolamine reduces apprehension and anxiety, potentiates analgesia, and does not alter blood pressure, pulse, or respiration. Patients appear to be calmer at the time of delivery, take anesthetics better and require less to obtain the degree of anesthesia desired. The incidence of postanesthetic nausea and vomiting is markedly reduced. Patients are relaxed during the postpartum period. There do not appear to be any deleterious effects on the newborn. Side effects are minimal and without consequence.

365 Roseville Avenue

Specialists Not Necessarily Superior

The question of whether designation as "specialists" carries the connotation of "superior" in the public's thinking, was raised* by Dr. Stanley R. Truman of Oakland, California, past president of the American Academy of General Practice. Dr. Truman described a town where many general practitioners do a great deal of specialty work. "The majority of them do some surgery, two do all the major surgery that come under that category. They are called in surgical consultation by the other doctors. Three of the other general practitioners do orthopedics. Other general practitioners do pediatrics and several act as consultants in medicine."

Dr. Truman considers the quality of medicine superior to average in the community he described. "Most of the men belong to the American Academy of General Practice and keep up in the graduate requirements for continuation of membership.

"There are numerous other communities in the United States that give a doctor similar opportunities to be a good general practitioner, and do the specialty of his choice in cooperation with his colleagues," according to Dr. Truman.

Dr. Truman* spoke of the restrictions put on general practitioners in some of the big cities, particularly in the East, "where general practitioners sometimes have trouble getting an appointment on a hospital staff. This seriously limits one's area of practice. Sometimes these restrictions against general practitioners are arbitrary and the hospital has closed its doors to anyone who does not list himself as a specialist. This is becoming less frequent. The practice probably arose from the desire of the administration and staff to have only the highest standards of medical practice, and the designation, 'specialist' has carried the connotation of 'superior' in our thinking for such a long time that this was an easy step to take. On the other hand, I do not doubt that it has been at times an economic tool to keep the work distributed among those who belong to the clique."

Dr. Truman is now one of the Commissioners on the Joint Accreditation of Hospitals.

*In the January 1960 *New Physician*.

M. L. Schwartz, M.D., *et al.*

Jersey City

Diuretics in Congestive Heart Failure*

In this systematic and carefully controlled study, it was found that systolic blood pressure could be reduced significantly after administering acetazoleamide or chlorothiazide. Chlormerodrin caused a good diuretic response but seemed to have little hypotensive effect.

The group of diuretic drugs which are effective when given by mouth include chlormerodrin (Neohydrin®), acetazoleamide (Diamox®), and chlorothiazide (Diuril®). Some therapeutic effects of these three drugs were the subject of our comparative study on patients in congestive heart failure. Blood electrolyte alterations were recorded when feasible.

Although the organic mercurial diuretics are usually injected parenterally some of them (such as chlormerodrin and mercumatilin) cause a water and salt diuresis on oral administration. Griffith and Butt [1] reported that long term oral mercurial diuretic therapy was useful in congestive heart failure. Oral compared to parenteral therapy was less likely to be associated with wide variations in fluid and electrolyte balance. According to these authors, azotemia, secondary to renal passive congestion, responded to oral organomercurials and *per se* was not a contraindication to these drugs. Acetazoleamide increased water, sodium and potassium excretion in edematous states when given by the oral route.[2] Haynes and Kahn [3] found that acetazoleamide controlled the edema of congestive heart failure without disturbing serum electrolytes. Although carbon-dioxide combining power decreased during therapy, acidosis was not a problem in these patients. More recently, chlorothiazide has been shown to have diuretic properties when given by mouth.[4] Beyer, *et al.*[5] reported that chlorothiazide inhibited carbonic anhydrase *in vitro*. In spite of this, however, the drug caused large and equimolar excretions of both sodium and chloride ions without inducing acidosis. Wener, Friedman and Schucher,[6] observed that one to two Grams of chlorothiazide caused a prompt diuresis in congestive heart failure due to several types of heart disease. The larger urine volume was accompanied by a significant increase in the output of sodium, potassium and chloride.

Following the introduction of chlorothiazide in the treatment of edematous states, several attempts have been made to compare its potency with the other diuretics. Ford, Moyer,

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1. Griffith, G. C. and Butt, E. M.: Ann. N. Y. Acad. Sci., 65:623 (1957).

2. Leaf, A., Schwartz, W. B. and Relman, A. S.: Southwestern Med., 35:549 (1954).

3. Haynes, B. G. and Kahn, K. B.: Med. J. Australia, 2:8 (1954).

4. Schreiner, G. E. and Bloomer, H. A.: New Eng. J. Med., 257:1016 (1957).

5. Beyer, K. H., Baer, J. E., Russo, H. F. and Haimbach, A.: Fed. Proc., 16:282 (1957).

6. Wener, J., Friedman, R. and Schucher, R.: Canad. Med. Assn. J., 78:592 (1958).

Handley and Spurr,[7] for example, using increase in sodium excretion as an end point, found that chlorothiazide was almost as effective orally as the parenterally administered mercurials. These comparisons, however, were based on the effects of single doses of the diuretic agents. The question therefore arose whether chlorothiazide would also show greater activity relative to the other oral diuretic agents when administered over longer periods of time. The aim of the present study was to compare the diuretic responses to chlorothiazide, acetazoleamide and chlormerodrin when each drug was given daily for one week. The design of the experiment was similar to the diuretic assay described by Greiner and Gold[8] except that the drugs were administered in therapeutic doses over longer periods of time. In our study, the heart disease was classified as arteriosclerotic (10 cases), rheumatic (7 cases), and *cor pulmonale* (1 case).

METHODS

THE diuretic effects of acetazoleamide, chlormerodrin and chlorothiazide were tested in twelve patients with congestive heart failure. The drugs were administered in the following doses which were given orally each day: acetazoleamide 150 and 300 milligrams, chlormerodrin 55 and 110 milligrams and chlorothiazide 1.0 and 2.0 Grams. Since the three drugs belong to different chemical and pharmacologic groups and have different levels of tolerance they could not be given in the same doses. From the results of an acute assay, Moyer, *et al.*[9] reported that 250 and 500 milligrams acetazoleamide produced the same diuretic response. In this study, therefore, doses of 150 and 300 milligrams were selected to see whether a dose-response relationship could be obtained when the drugs were administered daily over a period of one week. Six tablets per day of chlormerodrin or a total of 110 milligrams was the maximum dose used in this experiment for the following reasons: (a) Moyer, *et al.*[10] indicated eight tablets caused annoying side effects, (b) Evans[11] reported that 21 per cent of his patients receiving eight to twelve tablets per day suffered reactions requiring discontinuation of therapy and (c) our own clinical experience indicated that six tablets per day provided the maximum tolerated dose without symptoms of gastro-intestinal discomfort. Chlorothiazide, on the other hand, does not cause toxic side reactions at these levels and was given in doses of one and two Grams per day in this experiment.

The different doses of the three diuretics as well as the placebo were prepared in white capsules of the same size. The placebo was lactose. After being coded, drugs and placebo were distributed according to a schedule set up independently of those taking part in the actual assay. Because neither the observers nor the patients receiving the diuretics knew which medication was being dispensed, the criteria for a double-blind assay were fulfilled. The schedule was such that after one week of placebo therapy, the patients were given diuretic and placebo alternately for periods of one week each. The order of diuretics in each case was assigned at random.

Each week the patients were seen in the outpatient clinic. At this time their signs of congestive heart failure were evaluated. Changes in body weight, which were used as a measure of diuretic response, and arterial blood pressure levels were recorded. The drugs for the coming week were also prescribed at this time. Patients who developed signs of increasing congestive heart failure during this regimen and required a change in their therapy were excluded from this study.

In a second experiment six patients, three with rheumatic and three with arteriosclerotic heart disease, were studied. They received 300 milligrams of acetazoleamide, 110 milligrams of chlormerodrin, one Gram of chlorothiazide or a placebo daily. Medication was prescribed

7. Ford, R. V., Moyer, J. H., Handley, C. and Spurr, C. L.: Antibiotic Med. and Clin. Therap., 5:9 (1958).
8. Greiner, T. and Gold, H.: J. Am. Med. Assn., 152:1130 (1953).
9. Moyer, J. H. and Handley, C. A.: Chicago Med. Soc. Bull., May 10 (1958).
10. Evans, J. M.: Ann. N. Y. Acad. Sci., 65:612 (1957).
11. Wilkins, R. W.: New Eng. J. Med., 257:1026 (1957).

in a manner similar to that used in the earlier experiment. However, electrolyte studies were determined immediately before and after one week of administration of each of the above substances.

RESULTS

THE responses of one of the twelve patients with congestive heart failure receiving placebo and oral diuretic therapy on alternate weeks over a twelve week period are shown in figure 1. In this case of arteriosclerotic heart disease there was a decrease in body weight of at least two pounds after 300 milligrams of acetazoleamide, 110 milligrams chlormerodrin and after both 1.0 and 2.0 Grams chlorothiazide per day. The average changes in body weight after one week's therapy of the three drugs in all twelve patients are shown in figure 2.

Acetazoleamide. A significant diuretic response was measured in the twelve patients with congestive failure after 300 milligrams per day of acetazoleamide (Table 1). Although four of the twelve patients lost a pound or more after 150 milligrams per day, the mean decrease in weight of the group was not statistically significant. One of the patients who failed to respond to 150 milligrams acetazoleamide was the patient with chronic *cor pulmonale*. No toxic manifestations were noted after either dose when given over the one week period.

Chlormerodrin. The mean decrease in body weight of the twelve patients with edema after 55 milligrams per day of chlormerodrin was not statistically significant. However, after 110 milligrams chlormerodrin per day, nine of the twelve patients lost at least eight ounces and in four of these, there were weekly losses of more than 3 pounds. There were no toxic manifestations. None of the patients complained of nausea, diarrhea or other symptoms.

Chlorothiazide. After both the 1.0 and 2.0 Gram doses per day of chlorothiazide, the mean decrease in body weight was significant in the twelve patients with congestive heart failure. A loss in weight of a pound or more was measured in eight of the twelve patients

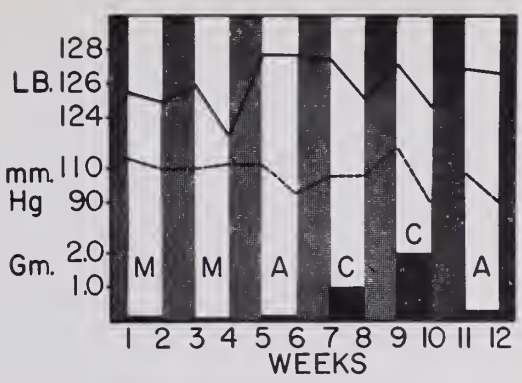


Figure 1. Changes in weight and mean arterial blood pressure in a patient with congestive heart failure during alternate weeks of placebo (shaded columns) and diuretic therapy (clear columns). A, acetazoleamide; C, chlorothiazide and M, chlormerodrin.

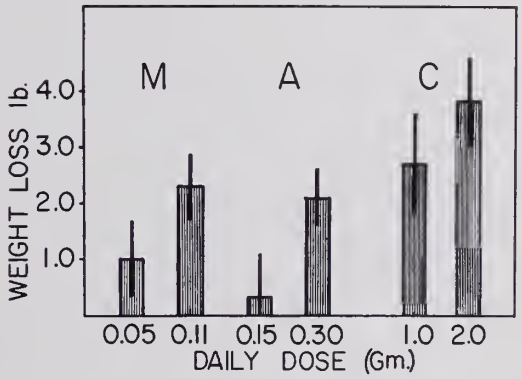


Figure 2. Mean reduction in body weight in 12 patients with congestive heart failure after one week of diuretic therapy. A, acetazoleamide; M, chlormerodrin and C, chlorothiazide.

TABLE 1.

ELECTROLYTES IN 5 CASES OF CARDIAC EDEMA

(Means in Milli-equivalents)

	Sodium	Potassium	Chloride	CO_2	Wt. Change (lbs.)
Control	144	4.4	103	29.2	--
Acetazoleamide	140	4.0	108	21.5	-2.47
Chlorothiazide	138	3.7	94	29.8	-3.98
Chlormerodrin	141	4.2	98	30.0	-2.33

after the 1 Gram per day dose and in eleven of the twelve cases after 2 Grams per day over the period of one week. No toxic side effects were observed during the week of therapy with chlorothiazide at either dose level.

BLOOD PRESSURE RESPONSES

Chlorothiazide has recently been reported to have hypotensive properties in arterial hypertension.[11] The decrease in blood pressure was observed whether or not there was cardiac decompensation. Because of this interest in the antihypertensive properties of chlorothiazide, the changes in blood pressure in response to each of the diuretics and in this study were determined. An average decrease in systolic pressure of 10 millimeters occurred in the twelve normotensive patients on acetazoleamide at doses of both 150 and 300 milligrams per day. The mean decrease in diastolic pressure, however, was not significant. The average decrease in systolic blood pressure in these patients with congestive failure was 9 millimeters after one Gram per day of chlorothiazide and 17 millimeters after 2 Grams. Chlorothiazide did not change the diastolic pressure of these patients significantly. No consistent changes in arterial blood pressure were observed after either dose of chlormerodrin.

SUPPLEMENTARY DATA

In the experiment in which six additional patients were studied, the following data were recorded (Table 1):

1. *Acetazoleamide,* 300 milligrams per day for one week, caused an average weight loss of 2½ pounds. The electrolyte changes were not significant except for an average reduction in carbon dioxide combining power. The mean drop in carbon dioxide combining power with standard error was 7.63 ± 2.36 milliequivalents per liter which was significant at the 0.05 level.

2. *Chlormerodrin,* 110 milligrams per day for one week, resulted in an average weight loss of 2.33 pounds. The electrolyte changes were not significant.

3. *Chlorothiazide,* 1 Gram per day for one week, caused an average weight loss of 4 pounds. The electrolyte changes included a serum potassium reduction. The mean drop in potassium was 0.73 ± 0.16 milli-equivalents per liter which was significant at the 0.05 level. Decreases in serum chloride and sodium which were not statistically significant in this limited series were also noted.

DISCUSSION

Assays of diuretic potency have previously been described using weight reduction in patients with edema (Greiner, *et al.*).[12] The data obtained from such experiments were capable of being analyzed statistically and were found to provide valid assays of diuretic activity. The assay design in this study was essentially similar to that of Greiner, *et al.* except that the diuretics were each administered over a period of one week. The present observations suggest the possibility that satisfactory dose-response relationships may also be obtained in long term experiments when alternating periods of drug and placebo therapy are scheduled in a double-blind fashion.

The aim of the present study was to compare the diuretic responses to chlormerodrin, acetazoleamide and chlorothiazide when given at the doses used clinically in treating congestive heart failure. Accurate quantitative comparisons of the relative activity of oral diuretics in patients with congestive failure can probably be made only among drugs of the same chemical and pharmacological class. When plotted, the dose-response relationships for the three drugs in this study were not parallel. Chlorothiazide produced the greatest fall in weight. However, it was also used at larger dose levels.

In three cases of congestive heart failure, the diuretic responses to chlorothiazide and mercuhydrin were compared by Wener, Friedman and Schucher.[6] They reported that 1 to

12. Greiner, T., *et al.*: Journal of Pharmacology, 103:431 (1951).

2 Grams of chlorothiazide were equivalent to 1 to 2 cubic centimeters of mercuhydrin intramuscularly. Both drugs were less effective during periods of hypochloremia. No attempt was made in the present experiment to increase the potency of the diuretics by giving chlorides simultaneously.

Electrolyte studies on patients in the second experiment revealed that serum potassium levels fell below the established normal range in some instances after one week of therapy with chlorothiazide. This is in agreement with other observers who also found significant decrease in serum potassium levels after chlorothiazide.[13] They recommended potassium supplements to the diet of patients on this drug.

SUMMARY

1. A double-blind study of the diuretic effects of acetazoleamide, chlormerodrin and chlorothiazide was carried out in eighteen patients with congestive heart failure. Blood electrolyte determinations were made on six of them. The cardiac failures were arteriosclerotic or rheumatic heart disease with one case of *cor pulmonale*.

2. Significant diuretic responses were measured after daily total oral doses of 300 milligrams acetazoleamide, 110 milligrams chlormerodrin and 1 to 2 Grams of chlorothiazide given over a period of one week. Significant decreases in serum potassium were noted after 1 Gram of chlorothiazide given daily for one week and in carbon-dioxide combining power after 300 milligrams acetazoleamide administered similarly.

3. The average systolic blood pressure fell 10 or more millimeters after 150 and 300 milligrams acetazoleamide per day and after 1 to 2 Grams of chlorothiazide but not after either 55 or 110 milligrams per day of chlormerodrin.

Acknowledgments: This study was supported by a grant from Merck Sharp and Dohme Research Laboratories, West Point, Pa. We are indebted to Drs. Maurice N. Re and Choo Y. Suh and Mr. Benjamin Levy for collaboration on the clinical aspects and to the entire outpatient staff, especially Mrs. E. L. O'Toole, for their cooperation in these studies.

13. Bayliss, R. I. S., *et al.*: Lancet, 1:120 (1958).

24 Baldwin Avenue

Anticoagulants Promote Recanalization

Anticoagulants are traditionally supposed to promote recanalization of a vein or artery occluded by a thrombosis. To test this thesis, A. Taylor and H. Essex did some experiments reported in *Circulation Research* (7:658) August 1959.

A 2.5-centimeter length of a peripheral ear vein was isolated with ligatures and a thrombus was produced in it by injecting a minute quantity of a solution containing 1000 units of thrombin per millimeter of saline. After 24 hours, when the thrombus was sufficiently adherent to the vessel wall, the ligatures were removed and treatment was started. With a stomach tube and syringe the rabbits were given bishydroxycoumarin (Dicumarol®) or ethyl biscoumacetate daily. The dose of these drugs was adjusted by the prothrombin time, daily determinations of which seemed to be necessary to avoid fatal hemorrhage.

In 10 of the treated rabbits the introduction of a radiopaque medium into the thrombosed vein distal to the thrombus showed complete recanalization after an average of 5.5 days, compared with 14.6 days in 13 control animals.

Sol J. Fanburg, M.D.

Newark

Prednisolone Aerosol in Dermatology

COMPARATIVE CLINICAL EVALUATION ON 134 PATIENTS

Newest development in dermatology is the use of the aerosol for delivering medication. Dr. Fanburg here points out the advantages of this method of administration compared to ointments and lotions.

Creams or ointments containing prednisone[1,2] or prednisolone[3-6] have been used successfully in certain dermatoses. This study was made to compare the effectiveness of prednisolone in a newer topical medium, an aerosol spray. The method apparently provides greater economy and ease of application. Preliminary reports by several investigators[7-12] indicate that the aerosol has several significant advantages over other forms of topical administration.

MATERIALS AND METHODS

The aerosol* contains 50 milligrams prednisolone in isopropyl myristate with propellant to a total of 150 Grams. A similar aerosol contains, in addition, 50 milligrams neomycin sulfate. Spraying the affected area for 3 seconds at a distance of 6 inches delivers approximately 0.5 milligrams of prednisolone or 0.5 milligrams of prednisolone and 0.5 milligrams of neomycin.

The cream* contains 0.5 per cent per Gram of prednisolone as the free alcohol; the ointment contains similar strengths of prednisolone and neomycin sulfate.

The placebo spray* was formulated with the propellant only.

There were 134 patients, of all ages in this series. Usually we made paired comparisons, in the same patient, of the aerosol and the cream or ointment, or the active aerosol and an inert vehicle. The aerosol and the cream were compared in 90 patients. The aerosol

1. Rein, C. R. and Bodian, E. L.: A Clinical Evaluation of Prednisone in the Treatment of Dermatoses. A.M.A. Arch. Dermat., 73:378 (April) 1956.
2. Robinson, H. M., Jr.: Prednisone in Treatment of Selected Dermatoses. J.A.M.A., 158:473 (June 11) 1955.
3. Frank, L. and Stritzler, C.: Prednisolone Topically and Systemically. A.M.A. Arch. Dermat., 72:547 (December) 1955.
4. Lowenfish, F. P.: Intramuscular Administration of Prednisolone in Dermatoses. Comparison with Oral and Topical Therapy. Internat. Rec. Med., 170:636 (November) 1957.
5. Sloane, M. B.: Topical and Oral Prednisolone in the Treatment of Dermatoses. Internat. Rec. Med., 170:59 (February) 1957.
6. Zimmerman, E. H.: Therapeutic Assay of Topically Applied Prednisolone Alcohol in Selected Dermatoses. J.A.M.A., 162:1379 (December 8) 1956.
7. Bodian, E. L.: Preliminary Report: Prednisolone in an Aerosol Spray. Internat. Rec. Med., in press.
8. Gant, J. Q.: Clinical Note: Meti-Derm® Aerosol in Dermatoses. M. Ann. District of Columbia, 27:525 (October) 1958.
9. Reiss, F. and Kallos, A.: Clinical Note: Prednisolone in Aerosol Form. A.M.A. Arch. Dermat., in press.
10. Robinson, H. M.: Prednisolone (Meti-Derm®) as an Aerosol for Dermatoses. A.M.A. Arch. Dermat., in press.
11. Yontef, R.: Prednisolone Aerosol. M. Times, in press.
12. Zelony, A.: Treatment of Dermatoses with Prednisolone Aerosol. Internat. Rec. Med., 171:661 (November) 1958.

*These materials were provided by G. Kenneth Hawkins, M.D., Division of Clinical Research, Schering Corporation Bloomfield, New Jersey.

with neomycin was compared with the ointment in 18 patients. The active aerosol was compared with the placebo in 19 patients. Seven received only the prednisolone aerosol.

RESULTS

IN THE study of the comparative effectiveness of the prednisolone aerosol and the prednisolone cream in 90 patients with various dermatoses, the relative antipruritic and anti-inflammatory effects of these two compounds, in the same patient, are summarized in Table 1.

Where itching was a factor, the antipruritic action of topical prednisolone was marked. Although there was little or no difference in effectiveness between the aerosol and the cream, the aerosol is preferable for dermatoses of the ear or anogenital region because it is easily applied to crevices and other relatively inaccessible areas. Pruritic conditions of the ear, such as seborrheic eczema, dermatitis venenata, or pustular otitis, responded dramatically to the aerosol. Relief of pruritus and diminution of the eruption in these conditions was greater with the aerosol than with the cream. In the other indications, good or moderate results occurred in nearly all patients except the three with psoriasis for whom both agents were ineffective.

The anti-inflammatory effect of the compounds was also approximately equal. It was especially notable in dermatitis venenata and eczema, and also occurred in atopic dermatitis, herpes zoster, dermatitis herpetiformis, insect bites, and pruritus *ani et scroti*. Vesicular, suppurative lesions dried, and erythema and edema subsided. There was no anti-inflammatory action in dermatophytosis, psoriasis, or lupus erythematosus.

The following case reports illustrate results among the 90 patients in whom the aerosol was compared to the cream.

1. A 49-year old woman had an eruption from a new pair of earrings. After treating herself with an ointment containing a local anesthetic she observed an acute, vesicular, edematous *dermatitis venenata* on both ears. She was advised to apply the prednisolone aeosol 4 times daily to the right ear, and the cream, in similar dosage, to the left ear. After 48 hours the edema and vesiculation on both ears had subsided; pruritus had disappeared from the right ear and was considerably diminished on the left. After an additional three days of therapy there was only faint erythema and scaling. This patient preferred the aerosol to the cream because manual application of the cream was disagreeable during the acute stage.

TABLE 1.

COMPARISON OF PREDNISOLONE AEROSOL AND PREDNISOLONE CREAM

Indication	No. of Patients	Age Range	Antipruritic Effect					Anti-inflammatory Effect		
			Excellent	Good	Moderate	Slight	None	Temporary	Present	Absent
Dermatitis venenata	45	3-71	*8*	*10*	*25*	*1*	*1*	—	*44*	*1*
			7	13	24	—	1	—	44	1
Eczema	12	13-74	—	*4*	7	*1*	—	—	*12*	—
			—	5	7	—	—	—	12	—
Dermatitis, atopic	10	3-65	—	*10*	—	—	—	—	*10*	—
			—	6	4	—	—	—	10	—
Dermatophytosis	8	35-68	—	*1*	7	—	—	—	*1*	7
			—	—	8	—	—	—	2	6
Herpes zoster	4	42-70	—	*3*	*1*	—	—	—	*4*	—
			—	2	2	—	—	—	4	—
Psoriasis	3	45-67	—	—	—	—	*3*	—	—	*3*
			—	—	—	—	3	—	—	3
Dermatitis herpetiformis	2	6-68	—	—	*2*	—	—	—	*2*	—
			—	2	—	—	—	—	2	—
Insect bites	2	47-48	—	*2*	—	—	—	—	*2*	—
			—	2	—	—	—	—	2	—
Lupus erythematosus	2	40-44	—	—	*2*	—	—	—	—	*2*
			—	—	2	—	—	—	—	2
Pruritus ani et scroti	2	30-50	—	*2*	—	—	—	—	*2*	—
			—	2	—	—	—	—	2	—

Italicized numbers indicate aerosol; roman numbers indicate cream.

2. A 40-year old man had been treated by another physician for chronic dermatitis seborrheica with a lotion containing bichloride of mercury. Within 24 hours after this treatment had been started, the patient developed an acute *dermatitis venenata* of the face and scalp. Prednisolone aerosol was prescribed for use 3 times daily and after 2 days the eruption subsided. He was then asked to use the prednisolone cream but discontinued medication after 2 applications; he prefers the aerosol because of its ease of application and greater effectiveness.

3. A woman of 60 had a 5-year history of *eczema* of the hands. Other forms of treatment, including roentgentherapy, had provided only temporary relief. Thrice-daily applications of the prednisolone aerosol were prescribed for the right hand, and the cream was used on the left. After 7 days of therapy eruptions on both hands subsided. The patient noted greater relief of pruritus with the cream and continued to use it for 2 additional weeks, after which time the eruption had subsided completely. There was a recurrence after 1 month which responded to applications of the cream.

4. A male, 20 years old, had a 10-year history of *atopic dermatitis* at the creases of the arms, legs, and neck. The skin had become lichenified and excoriated. Prednisolone aerosol was prescribed for administration to the right side and the cream form was used on the left. This patient preferred the cream because massage of the affected area seemed to provide greater relief of pruritus.

5. A 45-year old man presented an extensive eruption of *herpes zoster,* of 2 days' duration, on the right side of the chest. He was asked to use the prednisolone cream for 1 day and the aerosol thereafter. Relief of pain and itching occurred with both forms of topical prednisolone but the aerosol was considered superior because of its ease of administration: manual application of the cream had proved to be painful. After 1 week of therapy with the aerosol there was complete relief of symptoms; at follow-up 1 month later the patient was still asymptomatic.

The similar study, comparing the prednisolone and neomycin aerosol to the prednisolone and neomycin ointment, made in 18 patients, is summarized in Table 2.

The antipruritic effect of the prednisolone with neomycin aerosol was equal to that of the ointment in the patients with pyoderma (moderate benefit) and folliculitis (slight benefit). The aerosol was superior to the ointment in dermatitis seborrheica and in pustular otitis externa. A marked anti-inflammatory effect of both the aerosol and the ointment was observed in all patients in the above categories.

The following case report illustrates results among the 18 patients in whom the aerosol with neomycin was compared with the ointment with neomycin.

6. A 37-year old woman had *dermatitis seborrheica* for one year. There was considerable erythema and scaling of the scalp and ears. Mild dandruff had been noted for several years. Prednisolone with neomycin aerosol was prescribed for use on the right side, and the prednisolone with neomycin ointment was used on the left. After 2 days the patient began to use the aerosol exclusively because of its ease of application, efficiency, and superior antipruritic effect. After 10 days the eruption had subsided completely; twice-weekly applications of the spray kept the scalp in good condition.

Eleven patients with eczema, ranging in age from 14 to 79 years, were treated with both the prednisolone aerosol and a placebo aerosol. With the active drug, relief of pruritus was good in eight patients and moderate in three. With the placebo, there was temporary relief of pruritus in two patients and no relief

TABLE 2.

COMPARISON OF PREDNISOLONE WITH NEOMYCIN AEROSOL AND PREDNISOLONE WITH NEOMYCIN OINTMENT

Indication	No. of Patients	Age Range	Antipruritic Effect						Anti-inflammatory Effect	
			Excellent	Good	Moderate	Slight	None	Temporary	Present	Absent
Pyoderma	6	5-70	—	—	*5*	*1*	—	—	*6*	—
			—	—	6	—	—	—	6	—
Dermatitis seborrheica	6	25-60	—	*6*	—	—	—	—	*6*	—
			—	—	6	—	—	—	6	—
Folliculitis	4	24-30	—	—	—	*4*	—	—	*4*	—
			—	—	—	4	—	—	4	—
Pustular otitis externa	2	25-51	*2*	—	—	—	—	—	*2*	—
			—	—	2	—	—	—	2	—

Italicized numbers indicate aerosol; roman numbers indicate ointment.

in nine. A marked anti-inflammatory effect was noted with the prednisolone aerosol in all 11 patients; there was no anti-inflammatory effect with the placebo spray.

Eight patients with lichen planus, ranging in age from 23 to 79 years, were similarly treated with both the prednisolone and placebo aerosols in paired comparisons. In this indication, neither aerosol produced an anti-inflammatory effect. The prednisolone aerosol provided good relief of pruritus in one patient, moderate relief in four, and slight relief in three. The placebo aerosol produced temporary relief of itching in 5 patients and no relief in the other three.

Seven patients with pityriasis rosea, ranging in age from 8 to 35 years, were treated with the prednisolone aerosol. No control studies were made in this group; however, it was noted that the medication provided good relief of pruritus in five patients and moderate relief in two. No anti-inflammatory effect was noted.

Patients who received two agents were asked to express a preference. Of 12 with eczema who received both the prednisolone aerosol and the cream, four preferred the former. Of an additional 11 patients with eczema who received both the prednisolone and the placebo aerosol, all preferred the active agent. All ten with atopic dermatitis preferred the prednisolone cream.

In general, patients with chronic dermatoses preferred the cream to the aerosol, apparently because the massage which occurs with application of the cream is enjoyed rather than the reverse. A few patients, children especially, chose the cream because the chilling effect of the aerosol was considered disagreeable.

The prednisolone with neomycin aerosol was preferred to the comparable ointment by 4 of the 6 patients with pyoderma, all 6 patients with dermatitis seborrheica, and both patients with pustular otitis externa.

There were only two untoward reactions in the entire group. One patient with dermatitis venenata, who subsequently refused patch tests, evidenced local irritation following application of both the prednisolone aerosol and the cream. Previously, this patient had been found to be sensitive to many types of topical medication, including lanolin and petrolatum. Another patient with eczema thought the drying effect of the aerosol was excessive.

SUMMARY

Prednisolone (Meti-Derm®) aerosol, with or without neomycin, was administered to 134 patients with various dermatoses. In many patients, paired comparisons were made between the aerosols and similar creams or ointments. In most indications, the antipruritic and anti-inflammatory effect of the aerosol was equal or superior to the other forms of topical therapy. The aerosol has several advantages: it is easier to apply to creviced or hirsute areas, manual application to inflamed or suppurative areas is avoided, and the cooling and drying effect is usually desirable.

31 Lincoln Park

Booby-Trapped Bassinets

Bassinets at St. Peter's Hospital, Brooklyn, now are booby-trapped to prevent kidnapping. Each mattress is equipped with a battery-operated device that sounds off if an infant is snatched up quickly. (Apprehensive mothers can buy the same gadget for home use in crib or carriage for about $11.00).—Riss Edition, Medical Economics, May, 1959.

Fred Lerman, M.D.*

Irving Lerman, M.D.

Elizabeth

Management of Acutely Impacted Lower Ureteral Calculi

A Systematic Approach

Impaction of a lower ureteral calculus can offer the physician a very real management problem. In this brief contribution, the Doctors Lerman present a clear and step-by-step analysis of the technic of managing such a problem.

Treatment of any case of lower ureteral calculus—or, for that matter, of almost any medical problem—must be individualized in accordance with the many variables in each case. However, it is important to have a baseline approach: to have a definite plan in mind. When we do vary from that plan, we should realize that we are doing so and have definite indication for the variance.

Our intention in this paper is to give our baseline approach to the management of impacted lower ureteral calculi. The guiding principle running through this plan is to interfere as little as possible; and when manipulation becomes inevitable, to be as gentle as possible. Complications, both immediate and delayed, are inversely proportional to the gentleness of therapy. We divide our plan into six phases:

(I) Initial treatment; (II) First cystoscopy; (III) Post-cystoscopy; (IV) Second cystoscopy; (V) Manipulation; and (VI) Post-manipulation.

PHASE I: INITIAL TREATMENT

A middle-aged man enters the hospital with a first attack of acute right renal colic, accompanied by nausea and vomiting. We are fortunate enough to see him before any medication has been given. We prefer to start with morphine sulfate grain ¼ with atropine sulfate grain 1/150. If the man is large (200 pounds or more) and the pain severe, morphine sulfate grain 1/3 with a correspondingly larger dose of atropine is given without hesitation. Our experience with Demerol® for renal colic has been rather poor. In a number of cases, patients have failed to respond to an initial dose of 100 milligrams of Demerol® and one-half hour later we are in a therapeutic quandary. The morphine and atropine seems to be more frequently effective. An alternate mode of therapy, recently recommended in the literature, nerve blocking, has not yet been used by us and its effectiveness cannot be judged. It seems to be too cumbersome.

If the patient is relieved, routine workup now proceeds *via* intravenous urogram and so forth. We need not discuss the patient who has obtained relief at this time, since the treatment of any such patient with ensuing difficulty will be covered in the following discussion.

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PHASE II: FIRST CYSTOSCOPY

THIS phase considers the patient who has not been relieved by one or two doses of opiates. Immediately, we try to obtain an intravenous urogram. As indicated in the title of this presentation, this x-ray study will reveal a calculus in the lower third of the ureter, less than 7.5 millimeters in diameter, causing acute obstruction above it. Immediate cystoscopy should follow the intravenous urogram. From a practical standpoint, we have at times found it impossible to get an intravenous urogram immediately since it may be night, or the x-ray department schedule may be tight, and so on. In such cases we obtain at least a flat plate during the cystoscopy, and use intravenous indigo carmine to get an approximate estimate of the function of the opposite kidney.

Local anesthesia is used. Any measure, such as local anesthesia, which will help to reduce reflex ureteral spasm, is worthwhile.

A No. 21 F. Brown-Buerger cystoscope is used. When a No. 6 F. whistle-tip ureteral catheter can be passed by the obstruction it is advanced to the renal pelvis and left *in situ*. The single catheterizing telescope, or the convertible telescope (with fin removed) is used. If the double-catheterizing telescope with the fin is used, there may be difficulty removing the cystoscope while attempting to leave the ureteral catheter indwelling.

If a No. 6 F. ureteral catheter will not pass, we try successively a No. 5 F. olive tip, a No. 4 F. olive tip, and then a No. 5 F. with stylet. Once the obstruction has been passed, the catheter is not removed. If success has not been obtained, a general or spinal anesthesia is arranged as soon as possible. Then the same procedure is repeated. If still unsuccessful, a ureteral meatotomy is done under the same anesthetic if the calculus is in the intramural portion of the ureter. Either the cystoscopic scissors or the Bugbee electrode is used. We prefer the Bugbee electrode—in our personal experience the cystoscopic scissors has been uniformly ineffectual in achieving the desired controlled incision.

PHASE III: POST-CYSTOSCOPY

IF AFTER the meatotomy and unsuccessful passage of a catheter pain and/or chills and fever still persist, open surgery is then indicated and such patients move outside of this paper's sphere of discussion.

We now consider the patient who has had a catheter passed successfully with relief of hydronephrosis and pain. In the female when such a catheter is left indwelling, it is "splinted" with a No. 16 F. Foley catheter in the bladder. In the male a urethral splinting catheter is *not* used, since the difficulty which might be encountered during its insertion could dislodge the renal catheter and thus undo the entire procedure. Patients have surprisingly little discomfort voiding alongside a ureteral catheter. Sterile drainage is maintained from the ureteral catheter into a nursing bottle, and irrigations are done only as necessary. The ureteral catheter is left *in situ* approximately 48 hours. Following its removal, all urine is strained. The patient is placed on Probanthine®, 15 milligrams twice daily, as an aid in relieving spasm.

Now, with the catheter out, three main syndromes can occur:

1. Minimal or no pain, and the calculus is passed within 2 to 7 days. The desired result has been achieved.
2. Minimal or no pain without passage of the calculus. The patient is sent home to await further developments, and exits from our discussion of this topic.
3. Unrelenting or severe periodic pain, or persistently recurring fever. Further therapy is indicated. These patients enter into phase IV.

PHASE IV: THE SECOND CYSTOSCOPY

IN THIS phase, because of persistent pain or fever, the patient is again cystoscoped under local anesthesia (again using general anesthesia if necessary). If we are fortunate, a catheter is passed and is left *in situ*. No attempt is made at this time to extract the calculus. Further manipulation under spinal or general anesthesia is scheduled for 48 to 72 hours later. This planned interval allows time for acute inflammatory exudate and edema to subside.

PHASE V: MANIPULATION

FOR the manipulative effort we use no metal instruments. We confine instrumentation to

the Levant plastic basket and the new "hide-away" wire loops, such as the Mitchell. In our experience to date, the Mitchell-type loops have been superior to previous instruments.

Under anesthesia, we introduce a No. 21 F. Brown-Buerger cystoscope *alongside* the ureteral catheter which is still *in situ,* and do a ureteral meatotomy (if indicated by the position of the calculus at this time, but not previously done). We then remove the Bugbee electrode and introduce the Mitchell catheter, trying to pass it up the ureter again alongside the ureteral catheter. Then the splinting ureteral catheter is removed. The wire loop is exposed when we are well above the calculus site, and the catheter is then brought down very slowly, maintaining steady pressure. No rotation is done; we feel the results are better without rotation.

While the catheter is being introduced, an assistant holds the two sections apart so the loop doesn't expose prematurely; and while the loop is being brought down, the sections must be held together so the basket doesn't retract inadvertently. If the calculus is definitely engaged, the sections can be separated just enough to "lock" the calculus in its engaged position. This maneuver is repeated as much as three times, no more.

After the manipulation, whether successful or not, an attempt is made to leave a catheter indwelling to the renal pelvis. (The one exception to this rule is prompt and forceful excretion of indigo carmine upon extraction of the calculus, demonstrating an unobstructed ureter.)

PHASE VI: POST-MANIPULATION

FOUR possibilities arise following the manipulation:

1. *Calculus out, catheter in.* The catheter is left indwelling 48 hours, then removed and the patient discharged the following day.

2. *Calculus out, catheter not in.* We have had no significant trouble with these cases except for one or two days of pain until the edema subsides. The reason for passing the catheter, if possible, is to allow for good drainage during this period of edema, thereby eliminating pain.

3. *Calculus not out, catheter in.* The catheter again is removed after 48 hours. If pain or fever recur, then either part of the pathway must be retraced or open surgery may be indicated—here, individual considerations must rule.

4. *Calculus not out, catheter not in.* Open surgery is indicated. As a surgical procedure, we urge consideration of simple pyelostomy. The calculus might be imbedded in an inflammatory mass, and searching for the calculus in such an inaccessible inflamed area results not only in occasionally failing to find the calculus, but also in an avoidable incidence of serious strictures. Simple pyelostomy diversion of the urine is sufficient in most cases to allow the calculus to pass spontaneously once the edema subsides, or to allow for relatively simple later manipulation.

CONCLUSION

OUR EXPERIENCE with this planned systematic approach to the treatment of acutely impacted lower ureteral calculi has been highly satisfactory. The spacing of the intervals between phases has been carefully selected to avoid trauma and to allow for tissue response. Compressing this spacing to please the patient invites failure and complications.

1024 East Jersey Street

We are indebted to George R. Nagamatsu, M.D., Director of the Department of Urology, New York Medical College, for his helpful comments and suggestions during the preparation of this paper.

Paul De R. Kolisch, M.D.

Phillipsburg

Rupture of Gall Bladder Associated with Steroid Therapy:

Report of a Case

Steroid therapy inhibits inflammatory response. With gall bladder involvement, this may reduce fibroblastic proliferation and thus make rupture of the gall bladder more likely. Dr. Kolisch reports a case in point.

Ulceration of the upper gastrointestinal tract associated with steroid therapy has been frequently observed. The association of these lesions with systemic stress has been known for more than a century. Other lesions have been noted following steroid therapy; for example, metabolic bone changes resulting in compression fractures of vertebral bodies.[2] However, only one case of ruptured gall bladder associated with cortisone administration has come to my attention.[10] That case differs from the one reported below in that the earlier patient had acute, suppurative cholecystitis with cholelithiasis. This patient had been receiving steroid therapy for rheumatoid arthritis. In a search of the literature, I have found no case of rupture of the gall bladder, regardless of treatment, associated with leukemia.

A 53-year old coal dealer was admitted to the Warren Hospital with shortness of breath and "pounding of the heart." This was a complaint of recent origin (date not specified). He had been under treatment "for some time" for difficulty in micturition, and he had had difficulty in swallowing for many years.

He had herpetiform lesions about the nose and mouth. The gums were spongy, red and sore. There was marked diminution in breath sounds on the right side of the chest with some tracheal deviation. Rales were heard on the left. The liver edge was felt two fingers' breadth below the costal margin in the right mid-clavicular line and an impression of splenic enlargement was noted. The bladder was distended, and the prostate gland was enlarged and "boggy." Scattered, slightly enlarged lymph nodes were felt. It was thought he had pneumonia.

At the time of admission, red count was 3,120,000. Hemoglobin was 6.2 Grams. White count was 98,500 with a differential of 1 per cent polymorphonuclear neutrophiles, 1 band, and 98 "stem" cells.

The V.D.R.L. was non-reactive, the hematocrit 20 volumes per cent, and the B.U.N. 27.8. In the urine there were 25 red cells per high-powered field. Adrenocorticotropic hormone, 40 units, twice daily, was instituted. This medication continued for 5 weeks, for a total dosage of 2200 units.

Ten days after admission, the leucocyte count rose to 110,000; it was 145,000 a week later. Three weeks after that date it had dropped to 70,000. The last differential count showed 4 polymorphonuclear neutrophiles, 2 band cells, and 94 cells of the lymphocytic series. The diagnosis was acute lymphatic leukemia ("stem cell").

A bone marrow study showed essentially the same picture as did the peripheral blood. The marrow contained 3 polymorphonuclear neutrophiles, 2 band cells, 3 juveniles, 1 myelocyte, 1 promyelocyte, 1 metamyelocyte and 86 lymphocytes. Following treatment, the cells had matured enough to be recognizable, whereas earlier observations revealed only undifferentiated "stem" cells.

In addition to hormonal therapy, the patient received supportive therapy, including transfusions of whole blood, potassium chloride, and antibiotics for pneumonia (which was confirmed by x-ray).

X-ray study of the esophagus demonstrated marked dilatation, which the radiologist suggested could be the result of congenital atresia of the cardia. There was persistent infiltration of the right lung at this time and the radiologist thought of the possibility of bronchogenic carcinoma. Bronchoscopy, however, gave no evidence of endobronchial tumor. This included a study of exfoliated cells. Aspiration smear was negative.

A month after admission, the patient complained of severe abdominal pain, with some distention. There was no rise in temperature, pulse rate, or respiratory rate. Although a ruptured viscus was strongly suspected, operation was not attempted because of the patient's poor general condition. Antibiotic therapy alone was used. The patient died two days later.

At autopsy, the most striking gross findings were ruptured gall bladder and acute peritonitis. Five liters of bile-stained fluid were in the peritoneal cavity. The gall bladder wall was flaccid and averaged 2 millimeters in thickness. The rupture had occurred through a jagged, poorly defined area in the fundus. This tear was 20 millimeters in its greatest dimension. The consistency of the margin was similar to that of the rest of the wall. No calculus or mucosal erosion was noted. No calculus was found in the abdominal cavity.

Histologically, there was leukemic infiltration of the lungs, liver, spleen, and prostate gland. There was loss of lymph node architecture with uniform replacement of all cellular elements by medium to large-sized round cells with prominent nucleoli, margination of nuclear chromatin, and very little cytoplasm. Infiltration through the capsules of these nodes had occurred. The marrow of the vertebral bodies was filled with cells similar to those found in the lymph nodes.

The gall bladder showed interstitial edema, scattered infiltrates of atypical round cells, and what appeared to be precipitated bile at the edge of the perforation. The edema was slight to moderate in severity histologically. Grossly, the wall was quite soft and flaccid. The edge of the defect was friable, non-indurated and not thickened.

In addition to the evidence of steroid therapy effect manifested in the hemogram, the spleen contained no eosinophiles. Sevitt [12] found the normal number of eosinophiles in the spleen to be 200 to 700/hpf; the lower limit was 100/hpf. Any count below 50/hpf indicates adrenal hyperactivity. This is, undoubtedly, part of the picture of the "general adaptation syndrome."

Selye [11] has postulated that the "local adaptation syndrome" is reduced by the "general adaptation syndrome." This may explain the perforations that occur in previously existing ulcerations. Indeed, it explains the previously reported[10] rupture of a gall bladder that was complicated by cholelithiasis and suppurative cholecystitis. My own case shows no evidence of previous injury to the gall bladder. As a matter of fact, there was only a minimal degree of leukemic infiltration in the gall bladder, although such infiltration was marked in the liver.

It is possible that a small calculus, or even several such calculi, had been missed at autopsy, but this assumption cannot be substantiated. Diligent search failed to reveal any calculi. That failure is possible in so large a volume of fluid is self evident. However, other explanations may be offered.

For example, severe cholecystitis without stone, often associated with rupture, has occurred. Lichtman [8] writes: "There are cases with a fulminant course, abrupt onset, and without antecedent history of gall bladder disease. The patient may recently have recovered from some extrahepatic infection—in many instances biliary calculus is absent." Later, he adds, "Two sequelae mark this type of cholecystitis: a great tendency to perforation and suppurative cholangitis." Still later, he states that gangrenous cholecystitis develops in 14 per cent of all cases of acute cholecystitis and that spontaneous rupture of the gall bladder, without stone or cholecystitis, has been reported as a complication of the late stages of pregnancy.

The usual inflammatory response is inhibited by steroid hormones. The relatively bland appearance of the gall bladder wall in this case is, thus, readily understood. One might go still further and say that rupture in this case could be regarded as even more likely than in the ordinary case of postinfectious cholecystitis. With the depression of the inflammatory response, there is an accompanying reduction in fibroblastic proliferation. As a result, there would be no effective reaction of repair to destruction of the wall by the disease process.

It is of interest, too, that rupture of the gall bladder, without calculus or cholecystitis, has been reported as a complication of late pregnancy. It occurs to me that the physiologic demand of this period may, rarely, be sufficient to result in a "stress" situation similar to the case which is here reported.

SUMMARY

1. A case of rupture of the gall bladder associated with steroid therapy, in an individual with acute leukemia, is reported.

2. No calculus or severe disease of the gall bladder was found at autopsy. It appears that the rupture occurred without the expected inflammatory reaction owing to steroid therapy.

3. This patient had pneumonia when he was admitted to the hospital. He may have developed a postinfectious cholecystitis, which precipitated the rupture.

4. Characteristic changes of cholecystitis were absent owing to steroid therapy.

185 Roseberry Street

Thanks are expressed to Dr. J. J. Quiney, Jr. of Easton, Pa., for permission to report this case.

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Subtotal Gastrectomy

Postoperative complications of gastrectomy for duodenal ulcer are directly related to the problems encountered in the ulcer-bearing portion of the duodenum. These include blowout of the duodenal stump, duodenal fistula, pancreatitis, pancreatic fistula and trauma to the common duct.

It has been taught that removal of the offending duodenal ulcer is essential to surgical cure. Results from newer operations have cast doubt on the necessity for ulcer extirpation because of the good results following vagotomy or vagotomy plus drainage. Revaluation of the question was undertaken—whether ulcer removal or nonremoval is more beneficial. An unselective study of 300 cases was made.

The study showed that operative mortality was increased, from about 1 per cent to over 6 per cent when attempts were made to remove the ulcer. It is preferable not to resect the ulcer-bearing portion of the duodenum when the ulcer perforates very deeply into the pancreas.

—Rothenberg *et al.*: Surgery, 46:496 (1959).

Special Article • • •

JACK R. KAREL, M.D.

Elizabeth

Medical Civil Defense*

Lest we be lulled by the thought that "it can't happen here" we need, from time to time, a paper like this to remind us of some responsibilities that most of us have neglected.

HISTORY has shown that when the "chips are down" the doctors of this country were ready for any medical emergency that arose, whether it was in war, floods, hurricanes, explosions, railroad accidents, and so forth.

Since World War II, regardless of the apathy (a word I am beginning to detest) amongst the general public and the medical profession particularly, the lack of proper leadership by the Federal Government, the Congress, and State executives throughout the United States and especially by lack of medical leadership in the State Medical Societies, certain county medical societies in collaboration with the county Civil Defense and Disaster Control organization have gone ahead and developed excellent medical civil defense organizations. This has been possible only through the concerted effort of a hard core of individuals dedicated to Civil Defense. Many of them have given much of their time to the enhancement of local medical civil defense organization. In the past four years this constant pressure and enlightenment of the medical profession is beginning to bear fruit.

There is much to be done yet in enlightening every doctor about his medical Civil Defense responsibilities, but the opening wedge has been made. Naturally, more progress will be made in some areas than in others, but progress there must be. In this atomic and hydrogen age, space and missile activities, time is of the essence. The medical profession is the most important division of Civil Defense. We doctors must not falter and get behind the times. We must not show any sign of helplessness. We must demonstrate with our knowledge that survival is possible, especially when proper precautions are taken ahead of time. We must not sell ourselves or America short.

What can we as doctors do to enhance the capabilities of survival in the nuclear age? We can surely do something—giving a very small amount of time—even as little as one hour a month, or more if possible, to the cause of Medical Civil Defense throughout New Jersey. If we do this, we will show the general population of America that we doctors are not deaf when asked to think about defending ourselves against a possible nuclear attack.

How can we by devoting a small amount of time contribute to the survival of this country? The answer is to devote this time to the Medical Civil Defense program in each municipal and county civil defense organization. Medical Civil Defense may be divided into the following categories, each of which will be briefly touched upon: Organization, Emergency First Aid, Hospital Disaster Plans, Radiation Defense and Civil Defense Emergency Hospital.

*Developed from an exhibit at Annual Meeting of The Medical Society of New Jersey in Atlantic City, April 25 to May 1, 1959. Dr. Karel is Chairman, Civil Defense Committee, Union County Medical Society, Medical Coordinator, Union County Civil Defense and Disaster Control, and Member of the Special Committee on Disaster Medical Services, The Medical Society of New Jersey.

On March 10, 1955, the Governor of New Jersey signed a proclamation entitled *The New Jersey State Disaster Control Plan* part of which is as follows—"I do further proclaim that the aforementioned New Jersey State Control Plan and the requirements, rules and regulations set forth therein shall, according to their respective terms be binding upon all political subdivisions, public agencies, public officials and employees and upon each and every person of the State." This was the beginning of the State, County and Municipal Civil Defense Organization as we have it today.

EMERGENCY FIRST AID

EVERY doctor must become familiar with newer concepts of treatment in this nuclear age of such urgent conditions as hemorrhage, fractures, blast damage, shock and burns. Doctors must learn that the key to management of disaster victims is *Sorting*.[1] Under this heading the following divisions come into focus:

1. Casualties requiring minimal treatment
2. Casualties requiring immediate care
3. Casualties whose surgical treatment may be delayed without immediate jeopardy to life
4. Casualties whose therapy will be expectant (the most critical group)

To be effective, each municipal civil defense organization must have readily available medical teams to go to the scene of a disaster, able to function individually or to set up first aid medical posts throughout the community, for example, in schools. A mobile team to go to the disaster areas might consist of two doctors and a nurse or one doctor, one dentist and a nurse. Each should have available and easily transportable a first aid emergency kit about the size of an army foot locker containing essential medical supplies. The first aid medical post team would be a larger medical organization for emergency service.

Every hospital must have a *Hospital Disaster Plan*, for only then will the hospital be able to cope with large numbers of injured in a disaster. The Plan must be tried out so that the organization will function smoothly. The Boy Scout organization and Rescue Squads are very cooperative and willing to assist in this endeavor.

RADIATION DEFENSE

EVERY doctor must become familiar with the medical aspects of nuclear radiation. He must learn more about alpha, beta and gamma rays than he ever learned in medical school. He must have some basic knowledge of bomb fallout and how the bomb causes blast damage, burns and hemorrhage. It is essential that he know how much radiation a person can take each day and how much is lethal. The field of radiation is now a most important medical problem.

THE CIVIL DEFENSE HOSPITAL

THE final category in Medical Civil Defense is that which has come into being during the past three years and which is essential near potentially critical areas. This is the Emergency Civil Defense Hospital. It is a 200-bed, completely equipped hospital. The equipment, when packed, weighs approximately 13½ tons. The packaged unit can be loaded into one large van truck and transported when needed. The mission of this Civil Defense Emergency Hospital is to provide early hospitalization for the seriously ill and injured casualties as close as possible to the stricken area for life-saving, initial and reparative treatment or surgery. It is recommended that the supplies and equipment be set up in a pre-selected public building in time of emergency. Modern school buildings not more than two stories in height are preferable.

In establishing the medical organization for these Civil Defense Emergency Hospitals, the disaster plans of the fixed hospitals must not be disturbed. *Doctors for the Emergency Hospitals must come from those not having an assignment in a hospital disaster plan.* To accomplish and arrange a competent staff for the Civil Defense Hospital, it is advisable

1. Ziperman, H. H.: Symposium on Management of Mass Casualties. Brooke Army Medical Center, M317-28:116 (1958).

that there be collaboration between the Civil Defense Committee of the County Medical Society and the County Civil Defense Coordinator and his Medical Coordinator. Before such a meeting takes place, the Council of each county medical society must announce its policies to the complete membership and must stress each member's responsibilities to Civil Defense.

Civil Defense is here to stay and has become a way of life whether we like it or not. By joining in voluntarily with the thousands in other walks of life, to enhance the capabilities of Civil Defense, we will be contributing immeasurably a most important factor for our survival and the survival of this country, and giving notice to our potential enemy not to underestimate our people.

407 Jersey Avenue

Karl Menninger Challenges Walter Alvarez

Dr. Karl Menninger challenged the medical columnist, Dr. Walter C. Alvarez, who said that much of psychiatry has changed from a science to a religion with Freud as its prophet. Dr. Menninger also contested Dr. Alvarez's comment that: "Psychiatry has stagnated for the past 30 years."

In the January 1960 edition of *The New Physician,* official journal of The Student American Medical Association, Dr. Karl Menninger analyzed an editorial that had appeared in the same medical journal in September 1959.

Dr. Alvarez stated in September that he agreed with Dr. Corbett Thigpen, author of "The Three Faces of Eve," guest speaker at the 1959 convention of the Student American Medical Association, who said: "Under the dominating influence of theories of early sex trauma, psychiatry has largely stagnated, so that there has been little advance in it. Psychiatry may soon come out of the doldrums to become again a field for scientific research. Perhaps the change-over is now being effected by brain physiologists, pharmacologists, surgeons, and geneticists who are getting interested in the problems of mental disease. We will hope so. There is little hope of changing the mental processes of the older psychiatrists; they are too firmly set in their ways; and so our hope must be in the young men of the present generation. If they will accept only ideas for which there is scientific proof, we will get somewhere."

In his analysis of Dr. Alvarez's editorial, Dr. Menninger replied: "This has not been our (dynamic psychiatrists) understanding, but it is good to see ourselves as others see us, including Dr. Alvarez and Dr. Thigpen."

Dr. Alvarez's editorial was called, "A Remarkable Talk by an Honest Psychiatrist," and Dr. Menninger, in his rebuttal, wrote, "The implication of this title might be that either remarkable talks are usually given by dishonest psychiatrists or talks by honest psychiatrists are usually not remarkable."

When Dr. Alvarez wrote, "time and time again the audience (at the convention) was stirred to applause by the speaker's declaration that many of the ideas of modern psychiatry are just theories."

Dr. Menninger replied, "I, too, would have been impressed by this because in my day no medical students would have needed to be told that they did not have to swallow weird theories! The ascription of the adjective 'weird' is, of course, the judgment of Dr. Alvarez." Dr. Menninger added that "we know Dr. Thigpen as a respected colleague who has every right to his convictions about psychiatric theory. But we must be enormously embarrassed to be described as trying to get psychiatry out of the doldrums, and as pleading with his colleagues to be honest."

Trustees' Meeting: December 20, 1959

At its December 20, 1959, session, the Board of Trustees took the following actions:

—Received word from the State Board of Control that the terms of the Society's representatives on the Hospital Advisory Council would expire January 1, 1960. Request was made for recommendations for consideration of the Board. Noting that the Society's representatives—Dr. Mulligan and Dr. Blaisdell—"were distinguished members of our Board of Trustees and eminently satisfactory," they were recommended for reappointment.

—Authorized payment of our President's expenses to the White House Conference on Youth next March; and noted that the Governor had designated four New Jersey physicians as representatives. In addition to Dr. Bowers, the New Jersey representatives will be Doctors R. P. Kandle of Trenton, C. E. Spears of Chatham and William Ganss of Plainfield.

—Noted that our President had been invited to attend a forum in Boston in February on medical economics. This is sponsored by the magazine *Medical Economics* and Dr. Bowers has been invited as guest of the magazine.

Dr. Donnelly questioned whether any representative of the Society should attend as an official guest inasmuch as it could be interpreted as endorsement. It was felt, however, that a representative of the Society should be present. It was, accordingly agreed that the President or a member of the Board of Trustees attend the forum as the Society's representative, with expenses paid by the Society.

—Heard a report from Dr. Torppey, our representative to the New Jersey Diabetes Detection Program, that the State Department of Health is developing a teaching film on diabetes directed to general practitioners and medical students. It will be distributed gratis in New Jersey. The estimated cost of $30,000 for production of the film will be assumed by the State Department of Health, with some financial participation by pharmaceutical companies.

—Discussed proposals to change our legal formula for appraising the criminal responsibility of defendants. A State Legislative Commission is exploring this and our Executive Committee has reviewed it together with representatives of the New Jersey Neuropsychiatric Association. The Trustees adopted the following recommendation:

> The Medical Society of New Jersey recognizes that there may be certain deficiencies in the present statutes of New Jersey regarding the criminal responsibility of the mentally ill and mentally deficient, and that a very profound investigation is indicated. Therefore, in conformity with the recommendation of our Special Committee on Mental Health—concurred in by the Society's legal counsel—the Executive Committee recommends to the Board of Trustees that a special committee be appointed, consisting of representatives of the Medical Society, the Neuropsychiatric Association, and the Bar Association to investigate the matter and to report its findings and/or recommendations as soon as possible.

Subsequently, the President appointed the following representatives from the Society to the special committee:

Jesse McCall, M.D., Chairman
Luke A. Mulligan, M.D.
Joseph R. Jehl, M.D.
Robert S. Garber, M.D.
Vincent P. Mahoney, M.D.
Mr. Robert M. Backes, Counsel, *Ex-Officio*
Mr. Richard I. Nevin, Executive Officer, *Ex-Officio*

—Heard that Hospital Association wonders why our Medical Society did not take a position on the recommendations of the Public Medical Care Study Commission (as requested); the Hospital Association has renewed its request for Society approval of the recommendations. The Association is particularly concerned with the recommendations regarding reimbursement of hospitals for care of the needy. After discussion, the following was adopted:

> In light of additional information recently received, and without prejudice as to its stand on implementing legislation, the Executive Committee recommends that the Board of Trustees approve in principle the recommendations of the New Jersey Commission to study the Administration of Public Medical Care.

—Adopted a set of procedural recommendations for operation of the "New Jersey room" and conferences at AMA meetings.

—Heard that the New Jersey Hospital Association, and the American Hospital Association had formally recorded opposition to the Forand Bill.

—Was informed that the New Jersey Hospital Association was communicating with the Attorney General in reference to clarifying the regulations about administration of intravenous medication by nurses.

—Received a report from the Medical Director of Medical-Surgical Plan that the MSP Board of Trustees at its November 24 meeting had, by a split vote, defeated a motion "that MSP engage an independent public relations counsel, not a physician, who would be responsible solely to the Officers and Board of Trustees of MSP." Dr. Alfano indicated however, that the vote may not necessarily be final in respect to the matter, the possibility of finding likely candidates for the position is being explored; and will be scheduled for reconsideration.

Dr. Greifinger moved—seconded by Dr. McCall, and carried—that another letter be sent to the Board of Trustees of MSP urging reconsideration of their action to give this Society's opinion the weight that it should carry.

—Noted that our President and the Executive Officer of the Medical Society are invited to all meetings of the Trustees of Medical-Surgical Plan, and that at such meetings they have voice without vote. Yet our President *is* a voting member of the Board of Hospital Service Plan. It is believed that the President of The Medical Society of New Jersey is in a better position to convey the thinking of this Society to MSP than any other medical representatives on the Board, and effort should be made to provide the Society's President with official participation by voice and vote on the Board of Trustees of MSP.

The Trustees unanimously agreed with the President's expression. Dr. Donnelly moved —seconded by Dr. Greifinger, and carried— that the Board of Trustees recommend to the Medical-Surgical Plan that the Constitution of MSP be changed to grant the President of The Medical Society of New Jersey membership on the Board of Trustees of MSP with full privileges.

—Noted that the 1960 A.M.A. Medico-Legal Conference for state society attorneys and executive officers will be held in Chicago, on May 20 and 21. The executive officer and counsel stressed the value of these conferences, and urged the Board's consideration of sending representatives.

Upon motion by Dr. Sica—seconded by Dr. Schretzmann, and carried—the Board authorized the following to attend the conferences with expenses paid—Chairman of the Judicial Council, Executive Officer, and Legal Counsel.

—Received for signature a supplemental agreement to the Medicare Contract. The agreement will formally incorporate into the Contract the care restored to the program effective January 1, 1960.

The following types of care will be restored:

a. Certain surgery
b. Acute emotional disorders constituting an emergency. (In-hospital treatment limited to 21 days or less)
c. Pre- and post-hospitalization tests and procedures
d. Treatment of injuries on an outpatient basis

The supplemental agreement has been signed by the proper officers of Medical Service Administration (Medicare Fiscal Agent), and the committee recommends that the proper signatures by the officers of The Medical Society of New Jersey be authorized.

Upon motion by Dr. Ware—seconded by Dr. Sica, and carried—the required official signatures on the supplemental agreement were authorized.

—Received notice of the Society's membership dues for 1960 in the New Jersey Welfare Council. Our status is that of an "organizational member" with annual dues of $25. Request was made for consideration of advancing the Society's membership to that of a "sustaining organization" with annual dues of $50.

Upon motion by Dr. Allman—seconded by Dr. Schretzmann, and carried—the Board authorized payment of 1960 "organization" dues of $25.

—Heard a report from Mr. Backes, our counsel, that he had reviewed all papers concerning the proposed amendment to RS. 45:9-21 to include pathology and radiology technicians:

> It is my opinion that the objections stated by Dr. George G. Green, president of the Radiological Society of New Jersey, do not warrant interference with the proposed action to amend R.S. 45:9-21 as recommended by the Council on Legislation.

Upon motion by Dr. Greifinger—seconded by Dr. Sica, and carried—the opinion of counsel on the subject was approved.

Was informed that the Interprofessional Code of Physicians and Attorneys was adopted by the Burlington County Medical Society on November 12, and by the Union County Medical Society on November 11. Eleven county medical societies have adopted the Code to date.

—Heard from Dr. Kaufman that only 2003 affirmative returns were received from physicians agreeing to participate in the "senior citizen" policy. At least 1500 more were needed to meet the required 51 per cent. If this program is defeated by our own membership, it will be a public relations catastrophe for the profession. Dr. Kaufman proposed that a letter go to the membership over the signature of the chairman or President, or both, urging cooperation and participation in the program. Dr. Kaufman also suggested that members of the Woman's Auxiliary be asked to conduct a telephone campaign to the physicians in their own areas.

Dr. Greifinger proposed that if the membership is again circularized that another participating physician's contract be enclosed with the letter.

Dr. Kaufman moved that a supplemental letter with participating physician's contract be sent to the membership; and that the Woman's Auxiliary be requested to conduct a telephone campaign after the members have been properly circularized. The Board also directed that a copy of the communication be sent to the president of each hospital medical staff with the request that it be posted on the bulletin board. This motion was carried.

The Executive Officer informed the Board that he and the President were scheduled to attend the next meeting of the Union County Medical Society at which time they would stress the importance of each physician's participating in the program.

—Heard that The New Jersey Society for Relief of Widows and Orphans of Medical Men has a large fund, the income of which is used to help widows whose husbands were members of the organization. This aspect of the Society's activity is not well known, and Dr. Jehl suggested that the names of widows of physicians who are in need of financial assistance be sent to the Society. Assistance is given in amounts of $150 quarterly stipend plus $200 at Christmas.

Tuberculosis Today

A recent report prepared by the New Jersey Tuberculosis and Health Association and based on figures provided by the New Jersey State Department of Health, shows the need for continuous selective case-finding and prompt treatment if we are to bring the tuberculosis problem to an irreducible minimum.

In 1958, seven of our state's 21 counties recorded a higher active tuberculosis case rate than the state figure of 31.4. These rates are per 100,000 persons in the population. The counties with a higher rate were Atlantic, Cape May, Essex, Hudson, Mercer, Middlesex and Ocean. There was a 21 per cent decrease in the number of new tuberculosis cases reported. All told, 2,790 new cases of tuberculosis were reported in 1958 by the physicians in our state.

The highest active and "probably active" case rates were reported in the 65 and over age group* (57.6). The second highest was 48.9,* recorded in the age group 55 to 64 years. The case rate for persons under one year of age was 20. The lowest case rate (8.6) for the active and "probably active" cases was recorded in the age group 5 to 14.

Considering all the new cases recorded in 1958, the lowest case rate appeared in the 5 to 14 age group (10.2); the highest in the age group 65 years and over (113.2).

Almost two-thirds of the tuberculosis cases reported in 1958 were males. The number of males (1,792) and females (998) reported during 1958, represent a decrease over the 1957 total.

In 1958, the white population comprised 76 per cent of all the new cases reported, as compared with 78.7 per cent in 1957. During 1958 there was a reduction of 23.8 per cent in the number of new cases reported over the previous year among the white population. The non-white population showed a reduction of 9.8 per cent over the number of new cases reported during 1957. During the past ten years the number of new cases being reported have fluctuated. However, there has been a

*Per 100,000 population. The State average is 31.4.

gradual decline in the number of new cases being reported and a gradual drop in the new case rate.

In contrast to the morbidity rates for the past ten years, the death rates for the same period show a steady decline (excluding 1955 when the death rates showed a slight increase over the 1954 rate). The 1958 tuberculosis death rate represents the lowest death rate ever recorded in New Jersey. That was 8.3 in 1958 compared to 9.8 in 1957.

The private physician holds a key spot in tuberculosis prevention in New Jersey. Every physician should include a tuberculin test as a routine part of the examination of any contact, exposed person, or those with respiratory conditions, whether they are adults or children. The tuberculin test should be repeated (particularly where infants and children are involved) at periodic intervals. A periodic tuberculin test should also be administered to persons living in areas known to have a high rate of infection and disease. Repeated tests often lead to recent converters from a non-infected to an infected state. Many experts today agree that the use of prophylactic therapy, using one or more drugs, with these converters will prevent the development of a more serious disease. Tuberculosis is a preventable disease. Its spread can be stopped if every physician attempts to find and treat the unknown case.

It has been estimated that one-quarter to one-third of the American people are infected with live tubercle bacilli. One per cent of these people will probably develop into active disease.

Our present tuberculosis programs remain inadequate. Many known cases are not receiving treatment. Progress has been made in recent years. Yet, tuberculosis continues as a major health problem.

A free copy of the report *Tuberculosis Today* may be obtained from the New Jersey Tuberculosis and Health Association, 15 East Kinney Street, Newark 2.

—George N. J. Sommer, Jr., M.D., Chairman, Medical Affairs Committee, New Jersey Tuberculosis and Health Association.

Relief of Our Widows and Orphans

The Trustees of the Society for the Relief of Widows and Orphans of Medical Men urge all physicians who are in good health to apply for membership thus taking an active part in the work of this Society. Upon the death of a member an assessment of one dollar is made, and immediately 80 per cent of this sum is paid to the surviving widow, the balance going into the "permanent fund" for investment The income from the invested funds is paid out to widows or orphans who are in need. These payments are made quarterly plus a Christmas gift each year in sums dependent upon the need and the monies available from the investments.

Any physician knowing of a widow or orphans of former members who are in need will confer a favor upon them by notifying the Secretary of the Society at P. O. Box 95, Belleville, N. J.

Erratum

Attention is directed to a typographic error on page 731 of our December 1959 issue. This is in the article on "The Value of Twins to the Paternity Referee" by Dr. T. K. Rathmell of Trenton. The error will be found on the second line of the second column on that page. It now reads: eDe/ce. It should read cDe/ce.

This correction is published in fairness to Dr. Rathmell and in the interests of accuracy. The error was made in the editorial office and we apologize to Dr. Rathmell and his readers.

Presentation of Presidential Plaques and Certificates

193rd Annual Meeting

of The Medical Society of New Jersey

April 26, 1959

Presentation of Presidential Plaques and Certificates began at 4:25 p.m., Dr. Gardner presiding.

THE PRESIDENT: We will continue at this time with the presentation of the Presidential Plaques, which will be followed by an address by the A.M.A. President-elect, Dr. Orr.

We will ask the Fellows to be present on the platform. Dr. Ware will make the first presentation as Chairman of the Board of Trustees. This will be to Dr. Sommer and we will ask the Fellows, the Past-Presidents, to come to the platform to receive their plaques. Then we will ask them to be seated on the platform during the address by Dr. Orr.

The plaques which are being presented contain the seal of The Medical Society of New Jersey, in government bronze, and a name plate on a mahogany shield board engraved with the name of the Fellow, followed by the word "President" and the year of his presidency.

A certificate will also be presented, which reads: "The Medical Society of New Jersey presents this testimonial of sincere appreciation to"—and in this case the name will be "George N. J. Sommer, M.D., President, 1930, in recognition of his services to the State of New Jersey and to the medical profession. April 26, 1959."

Dr. Sommer, in behalf of The Medical Society, in recognition for your services to The Medical Society of New Jersey, it gives not only me but this whole Society pleasure to present to you this plaque. (Applause)

At this time we are going to have each Fellow or Past-President present the plaque to his successor. And the next President we would like to honor is Dr. Ely.

DR. SOMMER: There you are, President. I'm glad to give it to you. (Applause)

THE PRESIDENT: The next plaque to be presented will be to Dr. Snedecor by Dr. Ely.

DR. ELY: I'm very pleased to present this certificate to you for the work you have done for the Society. (Applause)

THE PRESIDENT: Dr. Snedecor will then present the plaque to Dr. Herrman.

DR. SNEDECOR: Dr. Herrman, it gives me great pleasure to present this plaque to you and particularly to remind you of Old Timers' Day at the State Medical Society.

DR. HERRMAN: Spence, there's a lot of people I would be very happy to have present this to me, but none that I would like any better. Thank you. (Applause)

THE PRESIDENT: Dr. Herrman will present the plaque to Dr. Hollinshed.

DR. HERRMAN: Dr. Hollinshed, it gives me great pleasure to present this to you for the State Medical Society and to tell you that we have something in common. You come from Gloucester. That's where my great-grandmother was born. (Applause)

THE PRESIDENT: Dr. Hollinshed will make the presentation to Dr. Royal A. Schaaf.

DR. HOLLINSHED: Dr. Schaaf, it gives me a great deal of pleasure on behalf of The Medical Society of New Jersey to present to you this plaque. (Applause)

THE PRESIDENT: Dr. Schaaf will present the plaque to Dr. Hornberger.

DR. SCHAAF: Dr. Hornberger, on behalf of The Medical Society of New Jersey, it gives me great pleasure to present this testimonial of your service to the Society. Tally Ho, Howard! (Applause)

THE PRESIDENT: Dr. Hornberger will present the plaque to Dr. Crowe.

DR. HORNBERGER: Aldrich, it's a pleasure on behalf of the Medical Society to present this plaque to you. We have made many momentous decisions together. (Applause)

THE PRESIDENT: Dr. Johnsen had to leave. Dr. Jehl, in lieu of Dr. Johnsen, I am happy to present his plaque to you. See that he gets it. (Applause)

Dr. Aldrich Crowe will make the presentation to Dr. Harrold Murray.

DR. CROWE: On behalf of The Medical Society of New Jersey, it gives me a great deal of pleasure to present this plaque to you. (Applause)

THE PRESIDENT: Dr. Murray will make the presentation to Dr Henry B. Decker.

DR. MURRAY: Henry, I'm very happy and honored to present to you this plaque for your tremendous help to me during my presidency. (Applause)

THE PRESIDENT: Dr. Decker will make the presentation to Dr. Elton W. Lance.

DR. DECKER: Dr. Lance, we will consider that you are Vermont's greatest contribution to The Medical Society of New Jersey, as this plaque will indicate. (Applause)

THE PRESIDENT: Dr. Lance will make the presentation to Dr. Vincent P. Butler.

DR. LANCE: Dr. Butler, it gives me great pleasure to present this plaque to you in behalf of The Medical Society of New Jersey. (Applause)

DR. BUTLER: Mr. President, before I make my presentation may I say how grateful we are, how appreciative we are. We want to thank the President and the officers of the Medical Society for this wonderful gesture in remembering us for what we have done. (Applause)

THE PRESIDENT: Thank you very much, Dr. Butler. I'm sure the officers feel that this is something that is long overdue and we are very happy to make these presentations at this time in recognition of the wonderful work that these men have done for the Society over the years. We just don't want to forget them.

Dr. Butler will make the presentation to Dr. Lewis C. Fritts.

DR. BUTLER: Dr. Fritts, it gives me great pleasure to present you with this commemorative token for all the good work you have done as the President of The Medical Society of New Jersey. (Applause)

Dr. Fritts will make the presentation to Dr. Gardner.

DR. FRITTS: Well, Ken, you have done a wonderful job this year as President of The Medical Society of New Jersey and I think everyone appreciates what you have done for us. (Applause)

THE PRESIDENT: Thank you very much. I'm very happy to receive this from Lew. We are old friends in the days back when we interned together.

And now I also have a pleasant duty to perform. Dr. Bowers, will you present yourself over here to the podium?

It is a pleasure for me to welcome you as the incoming President of The Medical Society of New Jersey. I know from my past experience with you, which has been most pleasant, that you will perform the duties of your new office with much ability, good judgment and strong leadership. It is my pleasure to present to you this Presidential Plaque inscribed: "F. Clyde Bowers, M.D., President, 1959-60." Congratulations. (Applause)

DR. BOWERS: As the neophyte in this organization, I feel compelled to say something. I feel a little abashed standing up here and accepting this plaque when I've not yet had the opportunity to serve as your President. However, with all these wonderful people who preceded me, I know I've got a tough row to hoe, but I certainly will do my best.

I want also at this time to let you know that this presentation here today again is an example of the Gardner touch. Actually, it was the President of our Society who suggested the presentations of these plaques to the Fellows, and the officers and the Board of Trustees went along. We are indeed grateful to you, Dr. Gardner. (Applause)

THE PRESIDENT: At this time we are very happy to have here two officers, one a past-President, one the President-elect of the American Medical Association. We would like to have them come to the platform. Now I ask Dr. David Allman to present to us Dr. Louis B. Orr, President-elect of the American Medical Association.

(Standing ovation)

THE PRESIDENT: If you will just be seated, I want to make a little speech.

Dr. Allman, as the immediate past-President of the American Medical Association, you have brought much honor and distinction to The Medical Society of New Jersey. In addition, you have given many years of service to our Society. In recognition of these services, you were elected a Fellow of The Medical Society of New Jersey. It is indeed a pleasure for me to present to you this plaque which is inscribed: "David B. Allman, M.D., President of the American Medical Association, 1957-58." (Applause)

Dr. Orr, The Medical Society of New Jersey is pleased to have you as our honored guest on this memorable occasion. It is the pleasure of our Society to have both you and your charming wife attend our Annual Meeting. We are the oldest medical society in this country, having been founded in 1766, ten years before the American Revolution. Our Society is pleased to have the privilege of preparing a plaque for you which is inscribed: "Louis M. Orr, M.D., President of the American Medical Association, 1959-60." And if we seem a little premature in making you the President of the A.M.A., it is only because we anticipate your installation to the presidency here in Atlantic City this coming June.

Dr. Orr, in the name of The Medical Society of New Jersey, I am most happy to present to you your plaque (Applause)

I'm going to ask Mrs. Gardner if she will present Mrs. Orr to us on the platform.

(Standing ovation)

THE PRESIDENT: The Medical Society is very pleased to have you with us today. We'd like you to sit up here while we listen to your husband for a few minutes.

To the lady who stood by me all these years.

(Presenting a bouquet to Mrs. Gardner)

I would like to ask Dr. Stuart Hawkes to come forward. I want to present to you the plaque that should have been presented to your father, Dr. E. Zeh Hawkes. (Applause)

Address by Louis M. Orr, M.D.

President-Elect, American Medical Association

193rd Annual Meeting

of The Medical Society of New Jersey

April 26, 1959

THE PRESIDENT: Now it is indeed a pleasure for me to present Dr. David Allman, a member of our own Society who has brought us honor and distinction. I ask Dr. Allman to introduce to you Dr. Louis M. Orr, President-elect of the American Medical Association. Dr. Allman.

DR. ALLMAN: Mr. President, Distinguished Ladies, Fellow Members of The Medical Society of New Jersey, and Guests: I didn't know until just this moment when I walked up here that I was to introduce Dr. Orr. But even without any forewarning I could do it amply and spend much time in doing it because his qualities and attributes are so many and I know them so well that I could keep you here for a long while telling you what a fine future is ahead next year for the American Medical Association. But I won't take all that time. I will do no more than to present to you the President-elect of the American Medical Association, Dr. Louis M. Orr.

DR. LOUIS M. ORR: Mr. Chairman, Ladies and Gentlemen: The nicest thing I've heard this afternoon since I have been in Atlantic City or since I have been on the road as the President-elect, and for many years back, is that Dr. Gardner spoke of me a moment ago as being "our" President-elect. That means a great deal more than just saying he is the President-elect of the A.M.A. When he said he is "our" President-elect, he meant that I am a part of New Jersey, and actually I am. This is my second home State and I'm going to tell you why.

In 1950 we got into a little political difficulty down in Florida with a Mr. Claude Pepper. We contrived ways of getting rid of Mr. Pepper. In so doing, the New Jersey people cast an ear in our direction and the one who cast the most acute ear was Dr. Joseph Londrigan. Well, Uncle Joe finally, in the course of time, asked me would I come up to New Jersey? That was my introduction to the State. I came into LaGuardia Airport in 1951. I came across town, came down to Newark, had a room reserved, but I didn't know there was going to be a political rally that night. The Robert Treat Hotel was filled with cigar smoke and big cigars, so I knew the Democrats were in action. So after a time I received a 'phone call in my room and the voice over the 'phone says: "Louis, it's Uncle Joe. Come on down."

I went down. I was ushered into this big room. Uncle Joe said, "Now, you know what you are going to do up here?" I said, "No." "We are going to have a political meeting tonight. You are going to make a talk. You are going to spend the night. Tomorrow night we are going to Trenton. We are going to give the boys down there the word." I said, "All right, sir."

In due course of time we attended this dinner. I gave a talk in Newark, which I thought was fairly satisfactory. And he said, "After we have done this, you better let me drive you around a little bit." He says, "I want to show you a little bit of Newark, then you go to bed and we'll go down to Trenton tomorrow night." I said, "All right."

I went outside and here was a character standing by the door, with his feet crossed like a gangster would, with his hat pulled down over his right eye. He says to him, "Louie, meet Dr. Orr." Louie says, "Hi!"

We got in the car and we started off in this Cadillac that Uncle Joe had. We drove around for a while. Uncle Joe says, "Park over here somewhere." The driver says, "Doc, I don't see no place." "See that sign over there where it says 'No Parking.' Park." We were out about a half hour. When we came back there was no police ticket on the car.

On our way to the train the next night the same question of parking came up down at Newark station. You know how busy it can get. There was a policeman over there—I'll never forget him—and a No Parking sign. Louie came up with the same thing: "Don't know where to park." Uncle Joe says, "That one over there with the sign on it." He says, "All right." Parked over there. I suppose when he came back the next day the car had been there all the time.

We got in the dark dining car. No service. Dr. Londrigan turns on the lights. We had sandwiches on the way down. Pulled out his card. No fare. Everything was fine.

We got down to Trenton. We were met by a rather small but enthusiastic group. And it was the original group; it was the "political action committee" of this Society. It was Dr. Schaaf, Dr. Allman, and they had an executive secretary and some of the other officials.

Well, we went over to this tremendous hall. It was a beautiful building, and apparently the townspeople had been warned that the British were coming or something like that and only sixteen showed up. But I want to tell you I did my best for New Jersey.

(Laughter)

When I went back to Orlando I felt a little like the man who had been brought into court on the charge of stealing chickens. And the judge had been a long time trying to secure an attorney for him; he was quite exasperated by the middle of the afternoon and he says to the defendant, "Look, this is going to be a rough day. And, by the way, are you the defendant?" This fellow's walking around a little bit, he says, "No, sir, judge. I'm just the one that stole the chickens." (Laughter)

Those are my ties to New Jersey and they are real ties and I say this is my second home society.

The other day in Orlando an elderly patient of one of my friends called up and said he was a little tired and worn out early in the afternoon. He asked if there was anything he could take that would perk him up a little bit. He said that in the past he could take a little nip and feel much better. Well, he was told to take a litte nip but don't overdo it. His wife called two hours later, and said, in an anguished voice: "Doctor, you have just undone the two years of effort it cost us to get my husband off of liquor."

That doesn't mean very much, but if that were the only problem we have those people who get to that fine age where they need a little nip in the afternoon, we'd have no worries. And what I'm going to refer to is the health care of the aged and discuss with you some of the problems in that field that we find ourselves in. Whether or not of our own volition is not important. We are in it.

You in New Jersey have taken one great forward step. You have agreed to adjust your fees to help meet the reduced incomes of our senior citizens who, we hope, will have insurance contracts at a reduced premium. That is ample proof of your concern.

This encouraging action by you has eliminated any need for me to suggest such a move this afternoon. But I would like to enlarge upon the profession's concern with the problems of the elderly, along with some of the recent actions of the American Medical Association to construct a program which is going to have a dynamic force, we hope, upon this government and the people of America.

The American Medical Association formed a Committee on Geriatrics in 1955. This was long before any legislation came from Congress. At its first meeting the committee decided that it could not limit its scope to problems connected with the diagnosis and treatment of older patients. There is practically no disease exclusive to old age. The committee members realized that they had to think in terms of both the sick and the healthy. The committee defined its province as all aspects of aging—physical, mental, social, occupational, emotional, cultural, and economic. Its name was changed at that time to the Committee on Aging.

The committee's aim was to devise a program that was idealistic yet practical, immediately applicable but far-reaching in its scope. Such a plan was developed and steps have been taken to put it in motion.

The first of these steps was the action of the American Medical Association's House of Delegates last December when that House adopted a proposal which applies specifically to the population group over sixty-five with modest resources or reduced family incomes. Your society has indicated its willingness to cooperate in the implementation of this policy.

Since this policy was announced, we have received many expressions of encouragement and support from members of Congress, the health insurance industry, newspapers, and from many other sources.

The second step to put this program in motion has been the action of state and local medical societies throughout the nation implementing the recommendation of the House of Delegates. Nine states so far have endorsed this action, and the matter is being given top priority on the agenda of thirty-four medical meetings scheduled for this spring, summer and fall.

A third move has been the denunciation by our House of Delegates of compulsory or arbitrary retirement based on chronologic age. This is most important. Such discrimination is harmful to the employer as well as to the older person.

Retirement certainly is a blessing for many people in their twilight years. But it should be voluntary, based on the capabilities and desires of the individual. Our Committee on Aging has asked labor and industry leaders to re-evaluate compulsory retirement policies. Studies are being made now into the possible effects of forced inactivity and isolation on mental health of the elderly.

I call your attention to a report that is going to come out in a magazine that you see in your food markets, called *This Week*. It has a circulation of some fourteen million. This positive plan will be in the form of an editorial in this magazine on an appeal to industry not to retire their people except on a voluntary basis.

A fourth action has been to meet with representatives of the health insurance industry to work out new insurance programs for people sixty-five and over. This has resulted in the Health Insurance Association of America asking its member companies to offer policies renewable for life, coverages that continue after retirement, coverages for those now over sixty-five, and policies which offer the holder the opportunity to convert from a group contract to individual protection when he stops working.

Now, this is all very good. In Blue Cross contracts we have some method for the elderly, for the low income groups to find satisfactory coverage for their hospital expenses. But I call your attention to something else that is giving me a great deal of concern. It is another one of those things we have to look at as a hurdle. Here is the *Wall Street Journal* of April 2, 1959. The headline is "Unionizing Hospitals. Drive Picks Up Speed in New York. Threatens to Spread to Raise Fees." Here is what they say:

"Mr. Sander, President of the 200,000-member American Federation of State and Municipal Employees, says that his eventual goal is to sign up 500,000 hospital workers in tax-supported hospitals across the country." 500,000! These are in tax-supported hospitals. Tax supported hospitals, you must remember, come under the purview of the Federal Mediation Board. Non-voluntary hospitals do not.

What do they say about a strike on a hospital? Mr. Feinstein, who tried to organize the New York City police a little while ago, says that "if the union does call a strike, we'll ask the hospitals to evacuate the patients." Where? He doesn't say. "We don't want to be put in the position of causing anybody's death. The hospital will have sufficient time to take the patients out."

The University of Minnesota Hospital's director, Mr. Ray Amberg, is now President of the American Hospital Association. Mr. Amberg has a hospital of 750 beds. He said, "Before unionization we got last-choice people; men and women who couldn't find another job. Now the caliber of the workers has improved." This is a quote.

What is the impact in the City of Minneapolis? In Minneapolis from the Swedish Hospital comes this statement: "Our Blue Cross full family group contract is around $10 a month, probably the highest for comparable coverage in the nation." In New York it is $5.43; $5.75 in Durham, North Carolina; $9.55 in Fargo, North Dakota.

In the *Wall Street Journal of three days ago,* the drug union threatens to strike six New York voluntary hospitals, not tax-supported. The New York *Times* of April 10th writes: "City acts to avoid six hospital strike."

On the one hand all of us are trying to write a contract that's going to give a Blue Cross contract or a policy with a premium that the people can pay for. At the same time we must realize what we are facing up to because it looks in every way we turn we find another hurdle and these hurdles must be met. But this is a serious side of the whole thing and it could be that by virtue of our own constructive plan such as Blue Cross we could be pricing ourselves out of our own market and into the hands of government. And I pray it never happens.

It will affect the commercial plans. Now they are working on these paid-up at 65 and the 65-plus policies. At the same time that I am telling you this today, 40 per cent of all the people over 65 years of age in this country are covered by some form of voluntary contract. The Health Insurance Association has stated that by the end of next year 60 per cent will have full coverage. This will rise to 75 per cent in 1965 and to 90 per cent in 1970. The actual growth may even outdistance the figures I've just given you. It *will* do so if the profession, that is, you, continue to act swiftly and with a bold imagination, and that you gentlemen must have today.

The fifth step has been to call attention to the need for health facilities designed for the aged. The major medical problems of older persons involve chronic illness and degenerative diseases. Adequate health care can be administered in many cases in the doctor's of-

fice, in the patient's home or in the home of relatives. The health care requirements of the aged range a full cycle from those who are able to care for themselves with no assistance to those who require 24-hour hospital care.

I was just out in Montgomery at the Air Force University and saw plans for some of the new hospital construction there. Instead of plumbing with steel and metal pipes, they are using plastics. Instead of steel partitions and wood and brick, it's all being done with plastic material, even to the doorknobs. These things are very light; they are cheap to construct, and they are portable.

There is also the plan that when a man has his appendix out he is put in an $18 a day room. He stays there for a couple of days. When he starts walking around, he starts walking to another kind of facility which is more or less of a convalescent home type where he pays only $10 to $12. And when he winds up his care, taking his sutures out after his operation, he is in a motel type of facility, walking downstairs to get his own meals and paying his own price.

Those are some of the things you will see in a while. We haven't done very much in progressive hospital care in this country. Some efforts are being made by having convalescent homes on the grounds of the hospital, but these things are coming ahead because we must meet them. As automation has met the problems in labor and industry, we are going to have to meet our problems by some imaginative plan to help in the reduction of the "hotel" costs of medical care. After all, it is not the physicians' charges and the physicians' care that is so expensive. You've got to separate these two things when you talk about the cost of medical care. The Consumer Price Index will tell you about the cost of surgeons' fees, general practitioners' fees and hospital costs. Incidentally, haircuts have risen faster than anything else in the book. Hospital costs come second. Doctors' fees are at the bottom of the whole list. Surgeons' fees are next to the bottom; the general practitioners' fees are next to that above.

When you take the Consumer Price Index and look at the level you will find that we are going right along with the price of everything else. But don't worry. In this climate, nobody fusses about the cost of a loaf of bread. It's what it costs to be sick. This is the thing you must wake up to; this is what you must realize. We are doctors. And what is behind it? It's this ever-creeping pattern. It goes back to the beginning of time, long before Lenin and Marx. People get their hands out.

Now, you've got another problem. You have a life expectancy which ten years ago was 65 years of age; now it's in the lower 70s. Right now fifteen million Americans are over 65, or one out of every 11 persons in this country. By 1970 that will be changed to one out of every 10.

This means more people are living longer every day. We must realize that we cannot hope to solve all the health problems of our senior citizens by medical care alone. More than anything, they need the opportunity to live healthy and comfortable lives.

The second reason for our concern and your concern is that if we fail to provide a workable scheme for health care for our senior citizens, there are those who are ready to step in, and I do not need to tell you who they are.

The tendency of the government to take matters into its own hands and keep them there should be a sufficient stimulus to all physicians of America who treasure their freedom to practice as individual, free practitioners.

Now, this has attracted one bill. You know it too well. You would regard it as highly dangerous. I certainly do. I'm referring to the Forand Bill. It would provide certain hospital, surgical and nursing home care for most Social Security beneficiaries. This bill is typical of the hasty or expedient approach to the problems of aging. It fails to take into consideration the psychologic, occupational, social or emotional aspects. Not one is mentioned, as our plan, the A.M.A. plan, has mentioned on all occasions.

You've got two different types of legislation. One is simply: put them in the hospital for 60 days or into a nursing home following the 60 days in the hospital or 120 days at your expense. The American Medical Association plan is trying to look at the total picture; but time is not on our side.

This legislation you could say is typical of the approach that people make when they cannot be bothered with looking below or beyond the consequences. But there are those who would endorse such legislation and such a policy on the short-sighted theory of "pass-a-law-and-raise-the-Social-Security-Tax-again."

This summer you will see in your areas a committee of Congress headed by Senator MacNamara. This committee is to talk about what they are going to do in 1960. This bill is not going to be pushed in 1959. This is not a presidential election year. What they are getting ready for is 1960. And this committee is to determine the climate of such legislation. And you know just as well as I do who is going to be in the meeting room when the hearings are held, unless you get up and drum up

a crowd, as some of your good union stewards are going to do for you. I call it to your attention. It's most important that this summer, when and if those hearings begin, Medicine must rise and present the other side of the picture, the majority side.

Let's go back a little bit. If you remember the old Murray-Wagner-Dingell Bill and some of the fussing and fuming that went on about the $25 that we were asked to give. Well, who wrote it? Arthur Altmeyer, Isadore Falk, Wilbur Cohen, and all the other boys. Where have they been all these years? Well, Wilbur Cohen is still in business. Arthur Altmeyer was the chief architect of the Forand Bill. And they are very busy; they have been all the time. The MacNamara committee is going to have as its adviser Wilbur J. Cohen. Wilbur has done pretty well for himself. At the present time he is Professor of Public Welfare Administration, Ann Arbor, Michigan—they've got a lot of it up in this area—formerly a member of two Communist front organizations cited by the Un-American Activities Committee for Communist connections; also formerly Assistant Director of Research and Statistics, Social Security Administration. Well, that's enough.

Now, those are some of the things we are going to be up against because you have never —and I do not foresee in our generation ever getting rid of this philosophy that still seems to be with us and behind the Forand legislation. Let us all remember that S-1056 is in the Senate. And what is it? It is the same Murray-Wagner-Dingell Bill with those parts of it which have already been accomplished deleted.

Washington observers say that this Forand Bill won't pass this year. But if you are going to prepare for battle against this undesirable legislation, you are going to have to think about bringing in your own plan to help the aged help themselves. That's one of the great duties that we have lost track of in the last 30 years. The American Medical Association program is steeped in the traditional American concepts of voluntary action by the individual. There is no compulsion; there is no dependence on the government; there is no financial burden on others, and no additional taxes to add to our already creaking fiscal structure.

This stepped-up taxation that would be necessary under the Forand Bill is just one of the reasons we vigorously oppose it. Many supporters of this legislation seem to think the financing problems would be insignificant. Insurance experts have estimated it will cost two billion dollars. And if you read the paper the other day you saw where Mr. Flynn, the Secretary of HEW, stated it would cost one billion dollars. So let's settle somewhere in there. But in any event, the total Social Security payroll tax will be raised to 11 per cent, and think of the number of people that work for you who one of these days soon, if this goes through, will be paying more Social Security tax than they ever paid income tax. And if you are self-employed, you will be doing the same thing within reason.

It is to be understood that the effect of such legislation would be to force that part of the population under 65 years of age to finance an indeterminate amount of health care for those over 65. It's the old business of the old robbing the young.

Philanthropy, you will agree, is fine when it is the philanthropist's money that is being spent. But some Americans are addicted to the curious philanthropy of spending other people's money and obligating future generations to pay the debts acquired today.

The theory of something-for-nothing reminds me of that old story of the king whose land was harassed by a shaky economy. He summoned his wisest counselors and told them to go out and bring in the answer. He gave them a year for the study. The wise men came back a year later with 67 volumes. The king said, "Go back. That's too much to read. I'll give you another year." In another year they came back with 34 volumes. "It's too much. I will never be able to find the answer in my lifetime. I'm becoming very old; I won't last long." Finally they came back with one little volume. The old patriarch said, "Sir, we have come up with the answer. There isn't any free lunch."

Now, that story does face up to the economics of a situation in which people believe that things can be accomplished which cannot be accomplished, particularly in reference to money.

Fortunately for us, many with similar views are beginning to support us; for example, here is one from the *Arizona Republic*, a paper you probably never heard of. This editorial calls the Forand Bill "one of the most dangerous pieces of legislation submitted to Congress in recent years. It would push the door wide open to socialized medicine. It would boost the already sky-rocketing social security taxes far beyond any level so far contemplated; but even these additional taxes would not pay the cost of the proposed services."

After providing health and medical care for old people, according to the newspaper, the next step 'will be for the advocates of a welfare state to ask the government to provide

medical services for the young and middle-aged as well as the elderly."

The Louisville *Courier-Journal,* in comparing the Forand Bill with the A.M.A. program for the aged, had this to say: "The A.M.A. stands a much better chance of holding the line against drastic change . . . by proposing some improvement of its own than by relying on public dread of socialized medicine to overcome public demand for added medical services."

Rather than merely offering opposition to this undesirable legislation, we also must mobilize the entire medical profession to help develop widespread, low-cost health insurance coverage for old people.

Above all else, our first concern is to offer what help we can to an ever-growing segment of our population which is of our own creation. Our assistance can smooth the sometimes rocky path into old age. Because a person has advanced in years is no reason he must be exiled from society or twiddle his thumbs until death ends the monotony.

Old age can and should mean the continuation of an active and rewarding life, perhaps at a modified rate. Perhaps in our approach to the subject of aging, we might keep in mind the words of an unknown author who said:

"Youth is not a time of life. It is a state of mind. It is not a matter of ripe cheeks, red lips, and supple knees; it is a temper of the will, a quality of the imagination, a vigor of the emotions.

"Nobody grows old by merely living a number of years. People grow old only by deserting their ideals. Years wrinkle the skin, but to give up enthusiasm wrinkles the soul. Worry, doubt, self-distrust, fear, and despair —these are the long, long years that bow the heart and turn the greening spirit back to dust.

"Whether sixty or eighteen, there is in every human being's heart the lure of wonder, the undaunted challenge of events, the unfailing child-like appetite for what next, and the joy of the game of living.

"We are as young as our self-confidence, as old as our fear; as young as our desire, as old as our despair."

(Standing ovation)

THE PRESIDENT: Thank you very much.

This will close this session. Thank you all for coming. It has been most instructive. We have been overly happy to have Dr. Orr with us. Thank you very much.

(The meeting was then adjourned at 5:20 p.m.)

Resolution on Death of Dr. Rogers

The following resolution, prepared by Dr. Paul Klempner, was adopted at a meeting of the Mercer County Component Medical Society, held November 18, 1959:

"Dr. Lawrence H. Rogers, who died October 14, 1959, dedicated his life to the care of the patients at Donnelly Memorial Hospital. He was associated with the hospital throughout his medical career as its Resident Physician, Medical Director, and Medical Superintendent.

"He was loved by the patients he treated, he was a friend to the hospital personnel with whom he worked, and he had many admirers amongst his colleagues who appreciated the services he rendered at Donnelly Hospital.

"Dr. Rogers will long be remembered by all with whom he was associated."

A copy of the foregoing resolution will be sent to the family.

Announcements • • •

Psychosomatic Seminar

A meeting of the American Society of Psychosomatic Dentistry and Medicine, will be held at the Shoreham Hotel, Washington, D. C., beginning Friday evening, March 11, through the afternoon of Sunday, March 13, 1960. Lectures and round table discussions will be led by authorities in semantics, linguistics, psychosomatics, and hypnosis. All dentists and physicians are cordially invited to attend. For detailed program, write to Dr. Jesse Caden, 5213 Connecticut Avenue, Washington 15, D. C.

Rehabilitation Demonstration

Technics which enable the handicapped person to achieve independence will be demonstrated at the Hospital Center, 189 South Essex Avenue in Orange at 8 p.m., March 30. The demonstrator will be Mrs. Edith Buchwald Lawton, a well-known authority and lecturer in the field of rehabilitation. All physicians are invited to attend.

Actinomycin Seminar

A conference on "The Actinomycins and Their Importance in the Treatment of Tumors in Animals and Man" will be held under the auspices of The New York Academy of Sciences at the Barbizon-Plaza in New York City on Thursday, March 31 and Friday, April 1, 1960. Doctor Selman Waksman of the Institute of Microbiology, Rutgers University, will serve as Conference Chairman. An invitation to attend the conference will be issued to interested professional persons upon request. There is no fee for those attending.

Requests should be addressed to Executive Director, The New York Academy of Sciences, 2 East 63rd Street, New York 21, New York.

Calling All Medical Women

Puerto Rico in the spring is the tempting target of members of the PanAmerican Medical Women's Alliance this year. The Alliance will assemble at the Condado Beach Hotel, San Juan, P. R. on June 3 for a 6-day seminar. Time allowance has been made for those who want to get to the AMA meetings in Miami that week. For details, write to Dr. Eva Cutright at 458 Beall Avenue in Wooster, Ohio.

Acting Dean for Seton Hall

Dr. Hugh G. Grady has been named Acting Dean of the Seton Hall College of Medicine to fill the gap left by the untimely and lamented death of Dr. Charles L. Brown.

A graduate of the Jefferson Medical College (1934), Dr. Grady's professional career has been largely in the field of pathology. He was, at one time, chief of the Division of Pathology of the Armed Forces Institute. Dr. Grady is now Professor of Pathology at Seton Hall.

Bergen Pines Residency Approved

Bergen Pines County Hospital has received full approval from the American Medical Association for a residency in gastroenterology. *This is the first gastroenterology residency approved in New Jersey.* Applications for this residency will be accepted only from physicians who have had two years of medical training in approved medical residencies. The appointment is for a period of one year.

The resident in gastroenterology will serve under Dr. A. I. Friedman, assisted by the staff of the hospital's gastroenterology section. This service covers in-patients and out-patients including training in endoscopy and other diagnostic procedures. The resident will serve in the weekly hepatology clinic. The section is part of the Division of Internal Medicine under the direction of Dr. Stewart F. Alexander.

County Society Reports

Atlantic

The regular meeting of the *Medical Society of Atlantic County* was held on December 10, 1959 at the Log Cabin, Margate City.

Dr. Louis Rosenberg, president, called the meeting to order. Eighty members were present in addition to medical students, interns, and residents and the following guests: Honorary Members—Senator Frank Farley, Mayor Joseph Altman, W. Elmer Brown, Counsellor for the Society; Other guests—Judge George Naame, Judge Leon Leonard, Judge Stephen Damico, Prosecutor Augustine Repetto, Mayor Warren E. Titus, Mayor Leon Leopardi, Frank Quigley, Ventnor City Clerk, Edward Fishman, President of Bar Association, Dr. J. Ward Weaver, President of Dental Society of Atlantic County, Dr. Benjamin Brown, President of New Jersey State Dental Society, Leonard Rosenstein, President of Atlantic-Cape May Pharmaceutical Association, Mike Fiore, President of Chamber of Commerce, L. Edison Mathis, President-Elect of Chamber of Commerce, Jerry Sullivan, Chief of Police of Atlantic City, Thomas Lindbergh, Administrator of Atlantic City Hospital.

The minutes of the previous meeting were approved as published in the December *Bulletin*.

Since there was no business to be transacted at this meeting, all business having been transacted at an Executive Meeting prior to the regular meeting, the speaker, Mr. Bosh Pritchard was introduced by Dr. Louis Rosenberg and by Dr. John Holland.

Mr. Pritchard is a former Philadelphia Eagle Star halfback and now vice president of Tel Ra Productions, world's largest producers of television sports films. He was an All-State halfback at Virginia Military Institute. He was on the "All-Time, All-State" Virginia team. His topic was "The Place of Sports in the World Today." He gave a thorough review of the professional football picture, starting in 1942 when he joined the Philadelphia Eagles. He reviewed interesting happenings of the World's Championship Eagles in 1948 and 1949. This was followed by a moving picture in which were depicted highlights of the recent football games, with commentary by James F. Leaming. In closing his talk, Mr. Pritchard answered questions from the floor and predicted that the Philadelphia Eagles were on their way to another championship team and possibly a new coach within two years.

Following this, a delicious buffet, catered by Mr. Pete Contini, was provided for all members and guests present. This meeting and party was one of the better public relations affairs of the Medical Society of Atlantic County in twenty years.

LEONARD B. ERBER, M.D.

Reporter

Gloucester

The monthly meeting of the *Gloucester County Medical Society* was held November 19, 1959 at the Woodbury Country Club. Dr. Dorothy M. Rogers, president, introduced Dr. Wohl, a member of the Pennsylvania Medical Society, who in turn introduced the guest speaker, Dr. John F. Muller, Associate Professor of Medicine at the University of Cincinnati. Dr. Muller gave a stimulating comprehensive discussion of nutrition and coronary artery disease.

Following Dr. Muller's address, a discussion was presented by Dr. James G. Kehler, and an informative question and answer period followed.

The business portion of the meeting then ensued. There were no October minutes since that was the "social night" held at the Tavistock Country Club during which an entertaining discussion was presented by a science instructor from the Hill School, on the physics of rocketry. In addition, there was a fine dinner at which we were happy to have as our guests the Executive Officer and the President of The Medical Society of New Jersey and their wives.

Letters of thanks from the guests who attended the social session were read and it was emphasized that all members should be certain to read the *News Letter* sent by The Medical Society of New Jersey as these are critical times for medicine and this is the best concentrated means for getting news to all members concerned.

The meeting adjourned at 10:50 p.m. and was followed by an excellent collation.

WILLIAM D. KEHLER, M.D.

Reporter

Hudson

The regular meeting of the *Hudson County Medical Society* was held at Jersey City Medical Center on January 5. Dr. Charles A. Landshof, President-elect presided.

Guest speaker of the evening was Dr. Christopher Martin, Director of the Division of Infectious Diseases, Seton Hall College of Medicine and Dentistry. Dr. Martin's topic was entitled "Major Changes in Our Knowledge of Pyelonephritis." Many members participated in a discussion from the floor.

A report was given by Dr. Frederick S. Barnes concerning changes in the Society's Constitution and Bylaws. These changes will be discussed and voted on at the next meeting.

ROY A. MORROW, M.D.

Reporter

Mercer

"Medical Aspects of a Trip to Russia" was the subject of a presentation by Dr. Richard E. Shope, of The Rockefeller Institute, at the January 13th meeting of the *Mercer County Component Medical Society.*

During a brief business meeting which followed Dr. Shope's presentation, a resolution, proposed by the Radiological Society of New Jersey, designed to curb the ever increasing inroads upon the private practice of radiology, constantly threatened by the hospital on the one hand, and Blue Cross on the other, was passed.

Physicians elected to membership during November and December, *Active*—Dr. Keith G. Battin, and *Associates*—Drs. Elmer Alpert and Thomas L. Evans, were introduced to their fellow members.

R. N. CAGAN, M.D.

Reporter

Middlesex

A special meeting of the *Middlesex County Medical Society* Board of Trustees convened at Roosevelt Hospital, under the Chairmanship of Dr. John A. Smith, on December 16, 1959 at 7:30 p.m.

A recommendation by Dr. Charles H. Calvin, Chairman of the Constitution and By-Laws Committee, that the County Society's Constitution and By-Laws be changed to comply with The Medical Society of New Jersey membership forms and procedures was accepted.

The suggestion that the Constitution and By-Laws be published in loose leaf binders was discussed and it was recommended that the Secretary procure estimates on the cost.

Delegates to the Annual Meeting of The Medical Society of New Jersey who had not attended the last two conventions or sent their alternates were replaced.

The Board was informed that the January 20, 1960 meeting was to be a joint meeting with the Legal Society (Middlesex County Bar Association). The Board passed a recommendation that the dinner be at the individual member's expense.

The general session of the Society was brought to order by the President at 9:00 p.m.

Dr. John Fenick of Carteret was elected to Regular membership from two years' Associate membership. He was sponsored by Drs. G. Frederick and G. J. Urban, Jr. Dr. Harold Kallman of Edison was elected to a two-year period of Associate membership. His sponsors were Drs. R. C. Steinman and Eugene B. Trachtenberg.

Dr. Martin Goldfield, Director of the New Jersey State Virus Laboratory, gave a talk on the ways his laboratory can be of service to clinicians. He recommended that all central nervous system suspected virus infections be investigated by sending in three stool specimens, spinal fluid, acute and four week convalescent bloods, and a short history of the case including date of onset. He requests that respiratory infection studies *not* be sent in except for cases of pericarditis, children's tracheobronchitis and spot checks on epidemics. Information on what specimens to obtain can be gotten by calling his laboratory.

THOMAS I. STEINBERG, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on December 15, 1959 at 9:00 p.m. at the Medical Society Building. Dr. Julian Cohen, president, officiated.

The following were elected to Active membership: Drs. Frank M. Ash and Pasquale Racaniello of Paterson; Theodore Ceraolo, David Eilenberg and Sidney B. Shane of Wayne; Herbert B. J. Gong of Haskell; John J. Jennings of Clifton; Ralph M. Talucci of Midland Park; James W. Murphy, Thomas F. Shivy and Paul D. Murphy of Pompton Plains. Also elected to Active membership by transfer from Bergen County Medical Society was Dr. M. Bernard Winkler of Paterson.

A resolution on the death of Dr. Abraham Shulman was adopted as read.

Dr. Cohen then read a proposed Amendment to the Constitution and By-Laws, and explained the reason for this Amendment which was unanimously approved. The text of the Amendment follows:

> "All Associate Members on January 1st, after having completed one year or more of Associate Membership shall be eligible for Active Membership. Their names shall be published in the October and November *Bulletins* preceding this date, and they shall be voted upon at the December meeting. Their dues shall commence on January 1st, following their election."

A resolution was presented by the Insurance Committee opposing a proposed rider to the present Blue Cross contract. This rider would extend coverage to hospital out-patients for diagnostic services, including x-ray and pathology. After full discussion, the resolution was adopted and a copy ordered sent to The Medical Society of New Jersey.

The meeting was then turned over to Dr. Edward A. Wolfson of the Program Committee, who introduced Drs. Marvin H. Sleisenger, Associate Professor of Clinical Medicine, Chief of Gastro-Intestinal Department; William A. Barnes, Associate Professor of Clinical Surgery, Attending Surgeon; and Nathaniel Finby, Associate Professor of Radiology, Associate Attending in Radiology, all on the staff of Cornell University and New York Hospital. Each of the doctors gave a brief lecture and a panel discussion followed with Dr. Andrew F. McBride, Jr., Chief of Surgery at St. Joseph Hospital, acting as moderator. A question and answer period followed.

Attended by more than 200 members, this was one of the most interesting and stimulating programs of the year, and there were unanimous expressions of gratitude to the Program Committee for obtaining the services of these five speakers.

At the conclusion of the scientific program, a collation was served at a table attractively decorated in keeping with the Christmas holidays by the hostess, Mrs. Irving T. Hayman, Hospitality Chairman.

IRVING CHRISMAN, M.D.

Reporter

Salem

The regular monthly meeting of the *Salem County Medical Society* was held on November 20, 1959 at Salem County Memorial Hospital with Dr. George A. Nitshe, of Elmer, presiding.

Dr. Harry F. Suter, chairman of the Public Relations Committee, reported on a recent meeting of the state Council. Favorable comments were noted regarding the increased use of *Junior Health Hints,* especially by the schools. Dr. Suter announced that a decal to designate physicians' cars was being considered.

A request for endorsement by the Medical Society was received from the Board of Trustees of the Salem County Guidance Center. This was given unanimous approval by the members.

The guest speaker, Dr. J. Rudolph Jaeger, professor of Neuro-Surgery at Jefferson Medical College, was introduced by Dr. Spangler. Dr. Jaeger's topic was "Tic Doloreux and Facial Pain." The speaker is nationally known for his successful injection treatment of severe nerve pains of the face and head.

After a question and answer period showing the interest in the remarks of the speaker, the members were the guests of the hospital for dinner.

G. F. REICHWEIN, M.D.

Reporter

Obituaries • • •

DR. WALTER J. FARR

Dr. Walter J. Farr, one of Teaneck's most useful citizens died on December 15, 1959 apparently as a result of injuries received when he was kicked in the chest by a horse. Well known as a breeder of fine palominos, the doctor was injured as he directed the unloading of a horse transport van.

Born in Hoboken in 1901, he received his M.D. from Cornell in 1925. After an internship in Brooklyn, he was associated in the practice of surgery with his father in Hoboken from 1926 to 1931 when he moved to Teaneck. He soon became affiliated with the surgical staffs of Holy Name Hospital and Valley Hospital. Since 1953, Dr. Farr had been a delegate of the Bergen County Medical Society to our House of Delegates. He was a lieutenant colonel in the China-Burma theatre during World War II. He had served a term as president of the Teaneck Kiwanis and was active in many civic affairs in the central Bergen County area.

DR. SAMUEL H. KRAEMER

Dr. Samuel H. Kraemer of Jersey City died at his home on November 21, 1959 at the age of 54. Born in Newark, Dr. Kraemer received his medical degree from the University of Maryland in 1930. He was on the staff of Christ Hospital and was a member of the Hudson County Medical Society since 1934.

DR. VINCENZO E. MATURI

Dr. Vincenzo E. Maturi of Bayonne died on November 8, 1959 while on vacation in Naples, Italy. Dr. Maturi was born in Italy and received his medical degree from the Royal University, Naples, Italy, in 1922. He was president of the medical staff of Greenville Hospital, Jersey City, was on the staff at Bayonne Hospital and was a member of the Hudson County Medical Society since 1927. He was a member of the American Academy of General Practice.

DR. GEORGE N. THOMAS

Dr. George N. Thomas, a prominent Cumberland County surgeon died on December 2, 1959 after a prolonged illness. Born in 1896, Dr. Thomas was graduated in 1923 from the Jefferson Medical College. In 1945 he became president of our Cumberland County component. He was chief of obstetrics at the Newcomb Hospital. Dr. Thomas did general surgery as well as obstetrics and was a frequent contributor to the medical literature. He had served the people of Vineland since the conclusion of his internship in 1924.

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Cardiac Arrest and Resuscitation. By Hugh E. Stephenson, Jr., M.D. St. Louis, 1958. Mosby. Pp. 378, with 31 illustrations. ($12.00)

Dr. Stephenson has written a comprehensive volume on a vital subject. He is joined by several noted contributors, which has enhanced this important work. The author has obviously made an intensively dedicated study of his subject. His record of the history of cardiac arrest is so complete that future writers on the subject can start with this book. A rich bibliography includes pinpointed references to the pertinent clinical researchers, physiologists, pharmacologists, and pathologists.

Although this was intended mainly for anesthetists and surgeons there is ample material for all physicians. The book touches on the medico-legal aspects of the subject. Perhaps the responsibilities of all doctors to do cardiac resuscitation may become a matter of real concern, especially when it is pointed out that a high proportion of cardiac arrest occurs outside of an operating room.

One unique aspect of his work involved the maintenance of a documented registry of over 1700 cases of cardiac arrest from which he was able to draw some of his conclusions.

HARRY A. LOTMAN, M.D.

The Care of the Geriatric Patient. By E. V. Cowdry, Ph.D., Sc.D. St. Louis, 1958. Mosby. Pp. 438. ($8.00)

"Bernard M. Baruch ranked the prolongation of life in the United States by eighteen years within a period of the last fifty years as having more implication for this and future generations than such technical developments as improved communication and transportation, mass production technics, and the development of nuclear energy." So wrote Howard Rusk. Few tasks facing the physician today are more difficult than the management of the geriatric patient with a chronic illness, or a disease that is as yet incurable.

This book by Dr. Cowdry and his 21 eminent contributors, provides a practical guide to the physician who is anxious to apply to his geriatric patient with chronic illness all that modern science has to offer to minimize suffering and to control as yet incurable conditions. The authors discuss in clear detail the physiologic, medical, surgical, dental and mental aspects of geriatric care. Drug treatment and nutritional requirements of the older patient are dealt with in a direct and precise manner.

The chapter on geriatric nursing is heartening and stimulating. It includes a psychiatric approach to the aged as well as the basic bedside nursing measures. Also very practical is a chapter on nursing homes. This covers the choice of nursing home, standards of care, economic aspects, and effectiveness to the patient. Rehabilitation is discussed from its many aspects and a chapter is devoted to Organizations and Services for older people.

The book is printed on good paper and easy to read. It is an asset to the library shelf of any doctor engaged in the treatment of older people.

SOL PARENT, M.D.

General Pathology. Edited by Sir Howard Florey, M.D. Philadelphia, 1958. Ed. 2. Saunders. Pp. 932. ($16.00)

The second edition of Florey's *General Pathology* is based on lectures at Oxford. The editor writes that this work is intended for the "better student" who has a good grounding in physiology and biochemistry. Florey's hope is to arouse his interest in the functional as well as morphologic aspects of pathology at an early stage of his career.

The book is not a complete survey of general pathology. It deals with subjects in which the contributors had special interests. There is, for example, discussion of the fundamental changes that take place in the body in response to injury, (using this word in a broad sense) and a review of present-day views on the nature of such changes. There is no discussion of special or specific organ pathology as such. However, the five chapters devoted to inflammation are excellently presented to aid the reader in developing his own grasp of the problem. Similarly the chapters on vascular disturbances (which include edema, thrombosis, embolism and atherosclerosis) cover the subject thoroughly and clearly in a general treatment to implement the reader's understanding as he confronts more specific discussion of these subjects

in standard texts. Also well handled are aspects of cellular retrogression and the response of cells and tissues to various types of injury. Here there is stress on deranged function within the cell including enzyme disturbances and biochemical changes. There are chapters on general aspects of neoplasia, the effects of irradiation on tissue, the response of tissues to micro-organisms, various aspects of immunity, hypersensitivity and the pathogenesis of tuberculosis. The book ends with two chapters on the influence of drugs on inflammation and the mode of action of antibacterial substances.

This is an excellent comparison text for the advanced or postgraduate student of medicine regardless of his special interests; and for the pathologist who wishes to broaden his viewpoints toward a more general understanding of the multitudinous minutiae of his daily activities.

SYLVAN E. MOOLTEN, M.D.

Anesthesia for Infants and Children. By Robert M. Smith, M.D. St. Louis, 1959. Mosby. Pp. 409, with 182 illustrations. ($12.00)

From his long experience as anesthesiologist to the Children's Medical Center in Boston, Dr. Smith has written a comprehensive yet readable book on pediatric anesthesia. He stresses the meticulous and specialized approach necessary with children to provide safe conduct through surgery. The anesthetic approach should not be as if the child were a "small adult." Factors such as surface area, temperature control, mechanics of breathing, endocrine control and fluid and electrolyte requirements are shown to vary markedly from the newborn to the older infant and less so throughout childhood.

The preparation of the patient for surgery with the personal evaluation by the anesthesiologist is stressed. The author recommends the premedication and anesthetic technics used in his department under various conditions and operations although he discusses other methods which can also be successfully used. The division into chapters of specialized subjects such as muscle relaxants, hypothermia and hypotensive anesthesia allows ready reference to the physiologic changes and technics used with these methods.

A clear, concise program is presented for the management of the infant under one year of age, The highest morbidity and mortality occur in this group. For the emergency patient who is toxic, febrile or has a full stomach, certain rules are set forth for pre-operative preparation and the anesthetic and recovery period. For those interested in anesthesia for the special branches of surgery as well as dentistry he has provided separate chapters outlining the problems and methods that these regions present.

The chapter on fluid therapy and blood replacement is a landmark in clarity on an often neglected yet vital subject. Several unusual features are the analyses of operative mortality and anesthetic deaths at his institution and some of the legal aspects of pediatric anesthesia. There are excellent illustrations of equipment, dosage tables, anesthetic records and frequent cross references combined with abundant citations to the literature.

Several of the technics used by the author might be questioned, such as electrocautery with ether in neurosurgery, yet under his conditions they have stood the test of time in a large series of cases. In circumstances like this, he feels that one should take the explosive risk rather than use a hazardous anesthetic technic.

This book on pediatric anesthesia, if carefully studied, will enable the anesthesiologist, surgeon and other medical personnel to make surgery in infants and children a pleasant and safe period.

TROY H. THROWER, M.D.

The Surgeon and the Child By William J. Potts, M.D. Philadelphia, 1959. Saunders. Pp. 225. ($7.50)

This fascinating book is written by a man whose name is well known in pediatric surgery. A pioneer in this field, he has written a book that any surgeon would enjoy. It is not a text, and there is a paucity of illustrations. Dr. Potts has written a group of monographs on pediatric surgical subjects. The material is entirely his own, and (except for a few references to Ladd and Gross) relies entirely on his personal clinical experience. Many of his statements are dogmatic and dictatorial, to sharpen the focus upon diagnosis and treatment as it is seen in the light of today's knowledge.

The chapters on anesthesia and cardiac arrest are most comprehensive. He unequivocally states that cardiac arrest in children is almost entirely preventable. For prevention he mentions the necessity of an empty stomach a free air-way, avoidance of too deep anesthesia and replacement of blood loss.

He modestly mentions his discovery in 1947 of the clamp that bears his name. This clamp has made many vascular operations possible and safer. His chapters on cardiac surgery are reports on his personal experiences in a large number of cases. He gives an honest appraisal of his successes and failures in this type of surgery.

The chapters on abdominal surgery are excellent. Atresia of the bile ducts, meconium ileus, intussusception, malrotation of the bowel, intestinal atresia and Hirshsprung's disease are well handled.

Dr. Potts has a facile style and would be interesting to read regardless of his subject. Typical is his discussion of portal hypertension, where he has this to say: "What is written in this chapter stems from our experience during the past twelve years with twenty-four operations performed on eighteen patients. Only impressions, not conclusions can be offered." Any physician would profit from reading this book.

GEORGE F. HEWSON, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

FEBRUARY, 1960 • Vol. XXXII, No. 2

TUBERCULOSIS AMONG THE NAVAJO

This account of a bold experiment in tuberculosis control is of great interest and import to everyone concerned with the ultimate eradication of the disease.

In July 1955 the Department of Public Health and Preventive Medicine, Cornell University Medical College, initiated a field health research project among the Navajo Indians in Arizona. The project, supported by the Navajo Tribe and the United States Public Health Service, developed from a Cornell research project in tuberculosis. The Navajos, now numbering 85,000, are the largest Indian tribe in the United States. They retain their own distinctive culture, language, and religion.

Tuberculosis has long been a major medical problem among them. However, during the past seven years, intensive efforts have had salutary effects on morbidity and mortality.

THE RESERVATION-WIDE PROGRAM

To understand what has happened, we should review the tuberculosis problem before the expanded Federal program became available in the fall of 1952. In 1950 tuberculosis was a leading cause of death on the Navajo Reservation. There was only one tuberculosis hospital with one hundred beds for the entire tribe. Case-finding programs were abandoned because beds for treatment were not available. Miliary and meningeal tuberculosis were commonplace even in adults. Estimates of active disease among Navajos ranged between 2 and 3 per cent, and infection rates measured by positive tuberculin reactors were 50 to 60 per cent among school children in the six- to ten-year age bracket. In 1952 two major changes occurred. (1) A government program of contracting with off-reservation sanatoriums to care for patients with active infectious tuberculosis was established. (2) The new and potent anti-tuberculosis drug, isoniazid, became available.

The sole facility for the care of tuberculous patients on the reservation—the 100-bed tuberculosis service at Fort Defiance, Arizona—was made the focal point of the program. Cornell University Medical College supplied the professional direction of this facility.

The impact of this "crash" program in hospitalization combined with the widespread use of isoniazid was soon demonstrated. By 1957 there was a 40 per cent drop in mortality.

During the past seven years the situation has improved. The miliary-meningeal problem is vanishing; no patient with active tuberculosis is required to wait for a hospital bed; and the tuberculin reactor rate among the six- to ten-year-olds in the reservation schools has fallen to levels of 20 per cent. The tuberculosis case register for 1958 for all Navajos showed that only 242 patients were now hospitalized, only 15 died of tuberculosis last year, and 171 were discharged from the sanatoriums and continued on chemotherapy.

It was obvious, however, that these gains in tuberculosis control might only be temporary unless some health measures could be extended into the home. A practical field program that would be effective had to be developed in the

KURT DEUSCHLE, M.D., *The American Review of Respiratory Diseases, August 1959.*

face of the cultural differences. Research was obviously needed and so the Cornell-Many Farms Project was initiated as a joint enterprise of the Navajo Tribe, the United States Public Health Service, and the University.

CORNELL FIELD STUDIES

The field health research project started in May 1956 and has been in continuous operation in an 800-square mile region in the Many Farms area of the Reservation. Within this district live 2,000 Navajos, about half of them in scattered camps in a dry sandy region; others in the mountains and canyons to the west. To date, 1,600 Navajos in the area have been in the clinic, where between 400 and 600 visits are made per month. Complete histories and physical examinations have been obtained on 75 per cent, roentgenograms of the chest in 80 per cent, and tuberculin tests on 62 per cent of the 834 children less than fifteen years of age.

During the period January 1957 to May 1958 the prevalence of tuberculosis in a subsection of the Project area was carefully studied. On the basis of the data obtained from films, tuberculin tests, and clinical examinations, the prevalence rate of tuberculosis among the 923 Navajos was 9 per cent for all forms of tuberculosis, 8.6 per cent for pulmonary tuberculosis, 7 per cent for reinfection pulmonary tuberculosis clinically significant by roentgenographic examination, and 2.1 per cent for active reinfection pulmonary tuberculosis diagnosed by roentgenographic methods.

After the children who were tuberculin reactors were identified, prophylactic isoniazid therapy was instituted for a period of 12 to 18 months. Approximately 120 children, age six to ten years, have completed this chemotherapy program.

Only one child out of the 300 followed in surveys from May 1956 to May 1958 was observed to convert from negative to positive.

About 40 patients were treated with isoniazid while ambulatory because of the presence of active or questionably active pulmonary disease. Thus, a total of 160 patients have been carried on a self-administered isoniazid treatment program during the past three years.

Of the 2,000 Navajos in the Project district, 59 have been hospitalized for active tuberculous disease. If this community picture of the disease is representative of the tribe as a whole—and we believe it is—the magnitude of the tuberculosis problem is clear.

Finally, in this connection, the effectiveness of the hospital and chemotherapy programs can be further appreciated when it is observed that no person in the community died of tuberculosis during the three-year period that the Many Farms project has been in full operation.

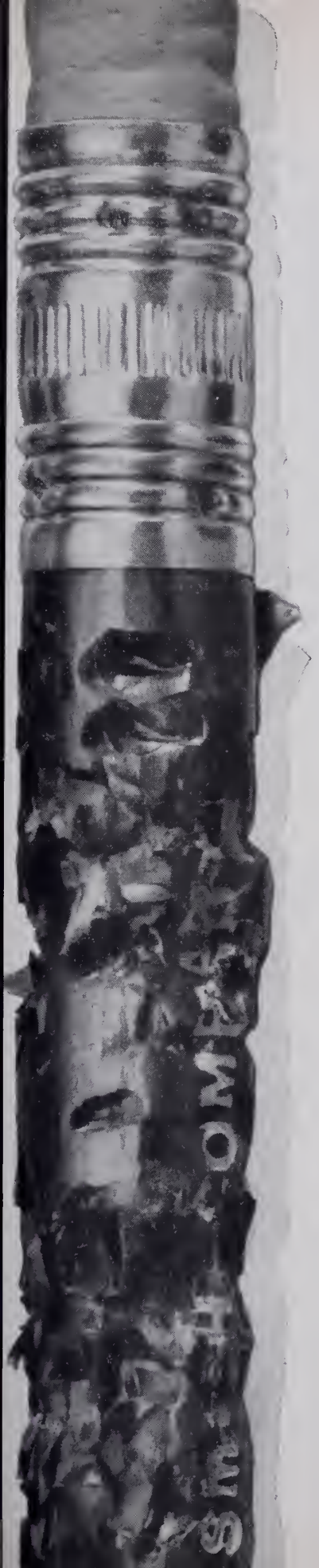
Despite firmly held traditional beliefs in the etiology of tuberculosis and in treatment by native healing ceremonies, modern medicine for the management of this disease has been accepted on the Navajo Indian Reservation. Since the advent of an expanded hospitalization and chemotherapy program, the tuberculosis mortality and morbidity have tumbled steadily downward. Nevertheless, the presence of 7 per cent of clinically significant disease on the basis of chest films still marks the Navajo as a tremendously high prevalence group.

To achieve and maintain the control of tuberculosis on the Navajo Reservation, the medical staff should be able to keep a constant check on about 2,000 patients with active or recently active tuberculosis. There may be another 4,000 Navajos with clinically significant inactive pulmonary lesions. What is required here is a carefully planned, community-oriented, field tuberculosis control program which can provide the necessary medical supervision.

Navajos have demonstrated a willingness to modify their traditions if they can be shown that change will lead to improvement. When physicians are also willing to modify some of their "scientific culture," the effective treatment of tuberculosis is assured.

Finally, it should be recognized that further and continuous control not only of tuberculosis but of all health problems in underdeveloped areas of the world requires an amalgamation of modern scientific techniques and a sensitivity to indigenous cultures.

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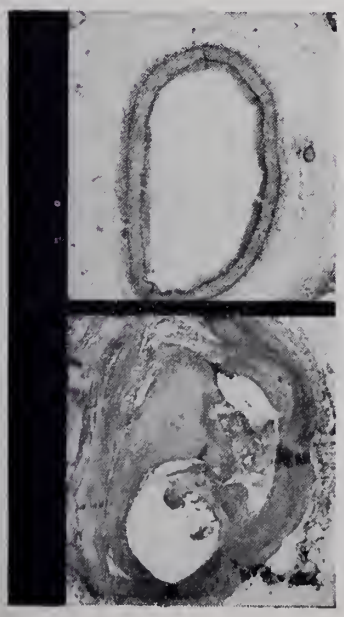
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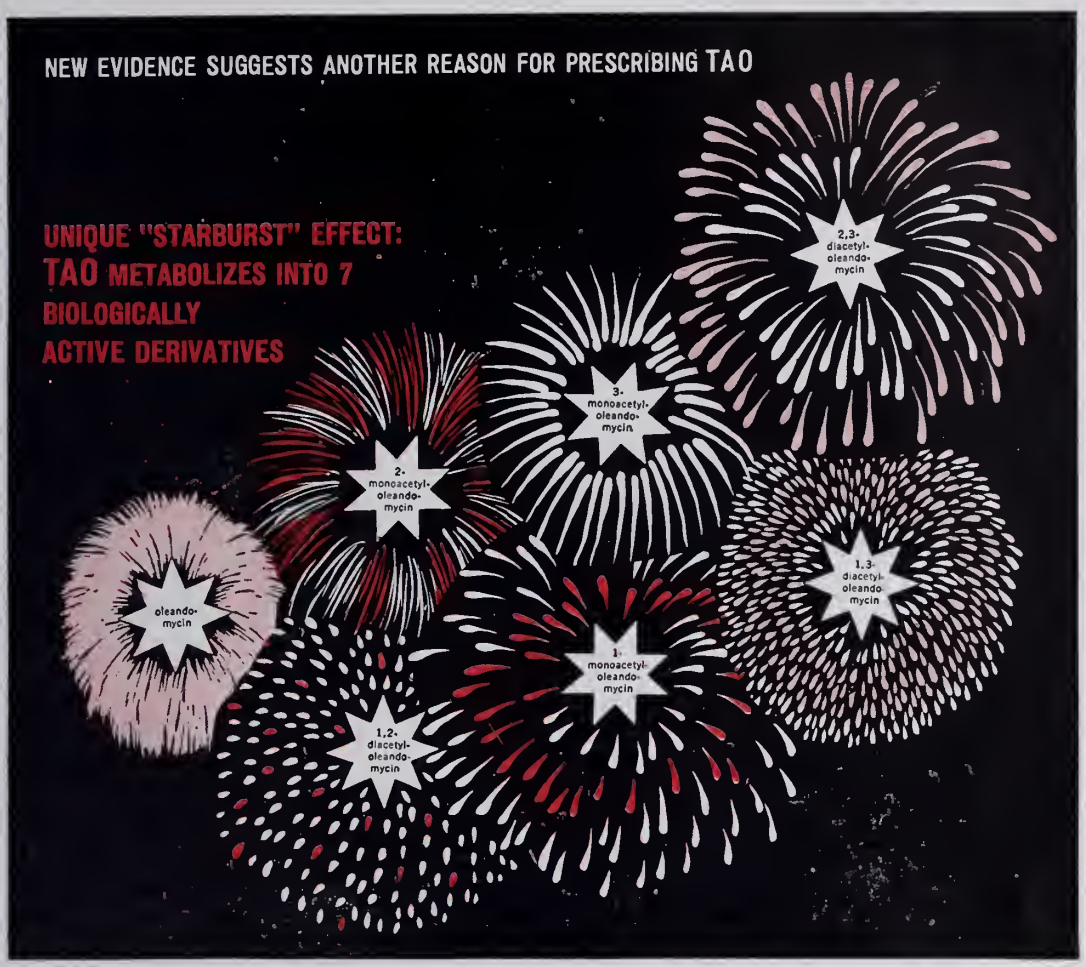
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genitourinary infection. Roberts, M. S.; Seneca, H., and Lattimer, J. K.,[1] New York, N. Y.—Ninety-one per cent of the Gram-positive and 27 per cent of the Gram-negative, among 66 organisms cultured from genitourinary infection, responded to DECLOMYCIN. Serum antibiotic activity was found three times greater than with tetracycline.

toleration. Boger, W. P., and Gavin, J. J.,[2] Norristown, Pennsylvania—Side effects with DECLOMYCIN were minimal. When dosage was 0.5 to 1 Gm. daily in divided doses, only two of 82 patients exhibited nausea.

activity level sustentation. Kunin, C. M.; Dornbush, A. C., and Finland, M.,[3] Boston, Massachusetts—Of the four tetracycline analogues, DECLOMYCIN Demethylchlortetracycline showed the longest sustained activity levels in the blood.

gonococcal infection. Marmell, M., and Prigot, A.,[4] New York, N. Y.—Of 63 cases of gonorrhea, 61 promptly responded after short courses of DECLOMYCIN. Therapeutic effect was found equal to that of intramuscular penicillin.

bronchopulmonary infection. Perry, D. M.; Hall, G. A., and Kirby, W. M. M.,[5] Seattle, Washington—Of 30 cases of acute bacterial pneumonia, all were afebrile following two to 10 days of treatment with DECLOMYCIN. Results were good in 21.... All of six patients with acute bronchitis responded promptly.

pediatric infection. Fujii, R.; Ichihashi, H.; Minamitani, M.; Konno, M., and Ishibashi, T.,[6] Tokyo, Japan—In 309 pediatric patients with various infections, DECLOMYCIN was effective in 75 per cent.

urogenital infection. Vineyard, J. P.; Hogan, J., and Sanford, J. P.,[7] Dallas, Texas—Clinical response in pyelonephritis correlated well with results of *in vitro* sensitivity tests, which showed some strains of *A. aerogenes*, Proteus and Pseudomonas more susceptible to DECLOMYCIN Demethylchlortetracycline than to its analogues.

pneumonia. Duke, C. J.; Katz, S., and Donohoe, R. F.,[8] Washington, D. C.—Results were satisfactory in all but two of 32 cases of acute bacterial pneumonia, of which only 11 were uncomplicated. No side effects were observed.

brucellosis. Chávez Max G.,[9] Mexico, D. F., Mexico—All of nine patients with *Br. melitensis* infection were afebrile after five days on DECLOMYCIN. Blood cultures were negative in all cases on the 20th day. Side effects were limited to slight temperature increases which abated in four days.

pustular dermatosis. Blau, S., and Kanof, N. B.,[10] New York, N. Y.—Results with DECLOMYCIN were excellent in both of two cases of impetigo, one of two cases of folliculitis, six of nine cases of furuneulosis, all of three cases of acne rosacea and 26 of 45 cases of acne vulgaris. Overall, results were excellent or good in 85 per cent.

antibacterial spectrum. Finland, M.; Hirsch, H. A., and Kunin, C. M.,[11] Boston, Massachusetts—DECLOMYCIN Demethylchlortetracycline was found the most effective of the tetracycline analogues against two-thirds of 680 normally sensitive strains of 15 separate species.

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Q What properties of KANTREX *led Yow to draw this conclusion?*

Next page, please . .

ycin sulfate injection (Bristol)

Q What properties of KANTREX *led Yow to draw this conclusion?*

a The following[2]: (1) KANTREX Injection is bactericidal, not merely bacteriostatic; (2) it is absorbed rapidly after intramuscular injection; (3) it has proved successful in many types of staph and gram-negative infections resistant to other antibiotics; and (4) it is well tolerated when used judiciously.

Q But if I use KANTREX *Injection, won't that help make bacteria resistant to it?*

a Numerous investigators have reported that micro-organisms do not readily develop resistance to KANTREX in a clinical setting; and emergence of resistance to KANTREX has not been a practical problem.[3,4,5,6,7,8]

Q How does the in vitro *activity of* KANTREX *against staph compare with that of other antibiotics?*

a Griffith and Ostrander[9] tested 794 strains of staphylococci and found that 95.2% were sensitive to KANTREX. By contrast, only 15.5% of the same organisms were sensitive to penicillin, 33.5% to tetracycline, 52.4% to erythromycin, and 71.7% to chloramphenicol.

Q What about the sensitivity of other pathogens to KANTREX*?*

a Leming[10] recently summarized the *in vitro* activity of KANTREX against 4493 strains of various organisms isolated from hospital patients over a 7-month period. He reported that the following percentages of these clinical isolates were sensitive to KANTREX: *Proteus mirabilis*, 98%; *Proteus morganii*, 94%; *Proteus rettgeri*, 89%; *Proteus vulgaris*, 87%; *Paracolobactrum intermedium*, 96%; *Coli-aerogenes* group, 93%; *Streptococcus viridans*, 78%; *Salmonella* and *Shigella*, 92%.

Q What do these figures mean clinically?

a A great deal. As Yow stated in recent reviews of KANTREX Injection, it "appears to be one of the most effective anti-staphylococcal antibiotics available today."[1,2] KANTREX Injection is also effective in the treatment of infections caused by "most strains of *E. coli, Proteus sp.*, the *Klebsiella pneumoniae-Aerobacter aerogenes* group, and many strains of *Pseudomonas aeruginosa* resistant to other antibiotics."[2] In another report, KANTREX Injection was placed at the head of the list of drugs "with the most chance of success" against *A. aerogenes* urinary tract infections.[11]

Q Have these findings about KANTREX *therapy been substantiated by other investigators?*

a Yes, indeed. Finegold,[12] who reviewed the clinical findings of 64 investigators, reported that infections which "usually responded" to KANTREX included: staph infections (including staph enteritis), *E. coli* infections (including *E. coli* gastroenteritis), atypical acid-fast bacillus infections, *Aerobacter-Klebsiella* infections, paracolon infections, *Alcaligenes* infections, *Shigella* dysentery, *Salmonella* enteritis, anthrax, amebiasis, and *E. histolytica* carrier state. Among the infections that "sometimes responded" were listed: pneumococcal infections, group A *beta*-hemolytic streptococcic infections, *Proteus* infections, gonorrhea, and paratyphoid fever.

Q That's an impressive list. What didn't respond?

a According to Finegold's tabulation, treatment failures were "usually" encountered in brucellosis, *Pseudomonas* infections, typhoid fever, mycotic infections and anaerobic infections.[12]

Q How long do I have to give KANTREX *Injection before I know whether it works or not?*

a Generally 2 or 3 days or less. Usually the effectiveness of KANTREX Injection can be determined in 24 to 36 hours. Rutenburg et al. reported that "the rapidity with which bacteria are killed by this agent is reflected by the promptness of the clinical response."[13]

MORE QUESTIONS on the clinical use of KANTREX®

Q *How long should I continue to administer* KANTREX?

a If definite clinical response does not occur within 5 days, KANTREX therapy should be stopped and the antibiotic sensitivity of the invading organism rechecked.

Q *What is the hazard of a patient developing hearing loss during* KANTREX *therapy?*

a In well hydrated patients with normal kidney function receiving KANTREX at the recommended dosage schedule, the hazard of ototoxic reactions is negligible. In patients with impaired kidney function, the risk of ototoxic reactions is sharply increased, and in such cases the dosage should be reduced. Finegold has stated: "Toxicity inherent in the drug can be avoided or minimized with careful management."[12]

Q *Why should renal impairment influence the dosage?*

a Because renal impairment delays the excretion of KANTREX Injection and causes an excessive accumulation in blood and tissues. Such excessive concentrations increase the risk of ototoxicity. Dosage recommendations emphasize that adequate serum levels can be achieved in such patients with a fraction of the dose suggested for patients with normal kidney function.

Q *Have you had any reports of blood dyscrasias?*

a None whatever.

Q *You mean, then, that a physician who uses* KANTREX *Injection judiciously should find it not only effective but also well tolerated?*

a Effective? Certainly, against almost all staph or "gram-negatives," even though they may be resistant to other antibiotics. Well tolerated? Yes, when given in recommended dosage. The physician can well agree with Yow, that while KANTREX Injection should not be used in mild or self-limited infections, "it should not be withheld in moderately severe or severe infections."[1] That, indeed, is the time to give it—first!

KANTREX® CAPSULES

for local gastrointestinal therapy...
not for systemic infections

Q *If* KANTREX *is not absorbed from the G.I. tract, what are the capsules used for?*

a Preoperative bowel sterilization, and local treatment of intestinal infections due to kanamycin-sensitive organisms.

Q *What types of intestinal infections, for instance?*

a Acute and chronic shigellosis,[14] acute and chronic salmonellosis,[4,14,15,16] amebiasis,[17] bacillary dysentery,[18] infantile diarrhea,[16,18] gastroenteritis,[19] and staphylococcal enterocolitis.[2]

Q *For preoperative bowel sterilization, why should I switch from neomycin to* KANTREX *Capsules?*

a Because KANTREX has been rated superior to neomycin for this purpose.[20,21,22] Out of 30 intestinal antiseptics studied, KANTREX was designated "the only single agent classified as a preferred drug."[21] KANTREX "consistently eliminated all aerobic bacteria within 72 hours (and often within 24 to 36 hours) if a purgative was given with the first dose to expedite passage through the gastrointestinal tract."[12]

Q *Is that all the advantage* KANTREX *has over neomycin for preoperative bowel sterilization?*

a Not at all, there are several others. Diarrhea, nausea and vomiting have not been observed with KANTREX, though they occur frequently with neomycin; yeasts do not proliferate, in contrast to rapid growth with neomycin; and clostridia are well controlled with KANTREX, and not controlled with neomycin.[20,21,22]

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In patients with impaired renal function or pre-renal azotemia, the dail[illegible] should be reduced to avoid accumulation of the drug in serum and t[illegible] the possibility of ototoxicity. In such patients, if therapy is expected to l[illegible] audiograms should be obtained prior to and during treatment. KANTREX [illegible] stopped if tinnitus or subjective hearing loss develops, or if audiogram[illegible] of high frequency response.

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KANTREX should be used by intravenous infusion only when the intr[illegible] practicable. KANTREX can also be employed for intraperitoneal use, as [illegible] an irrigating solution. See package insert for directions.

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INDICATIONS AND DOSAGE

For preoperative bowel sterilization. 1.0 Gm. (2 capsules) every hour f[illegible] 1.0 Gm. (2 capsules) every 6 hours for 36 to 72 hours.

For intestinal infections. Adults: 3.0 to 4.0 Gm. (6 to 8 capsules) per day [illegible] 5 to 7 days. Infants and children: 50 mg. per kg. per day in 4 to 6 divided [illegible]

PRECAUTION

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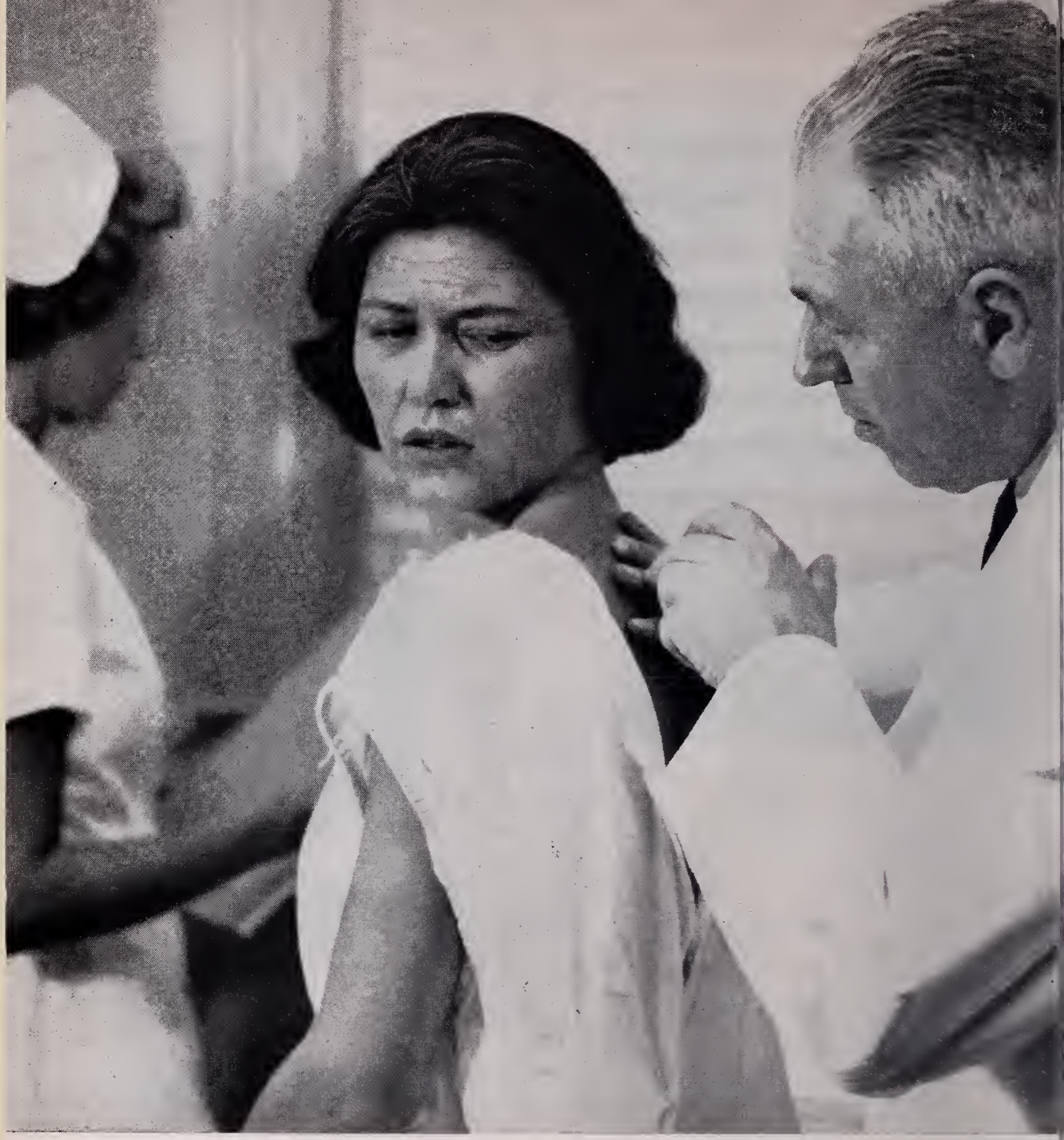
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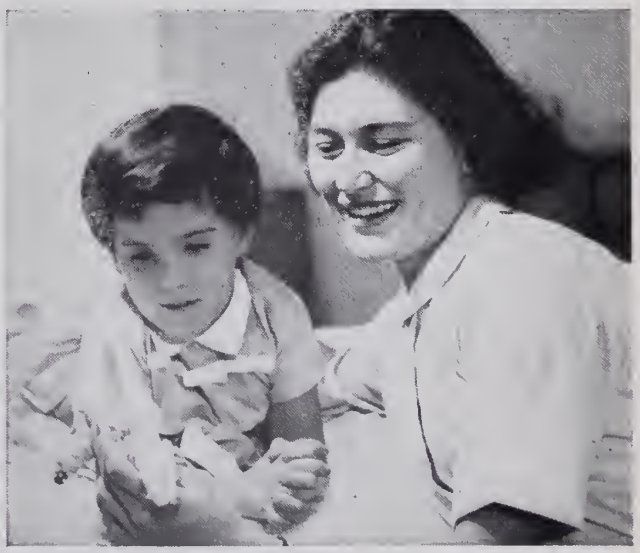
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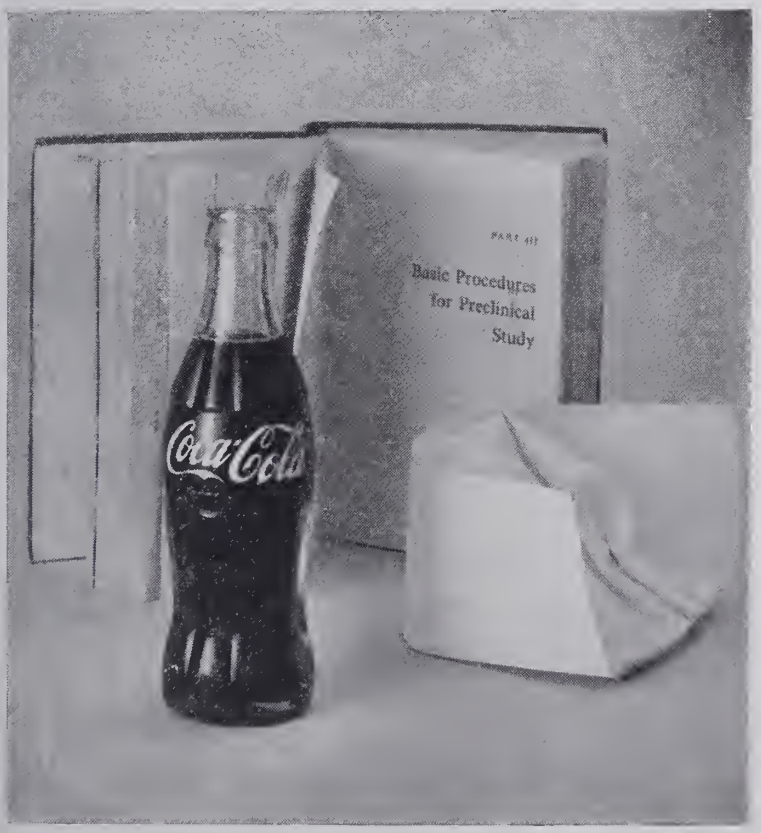
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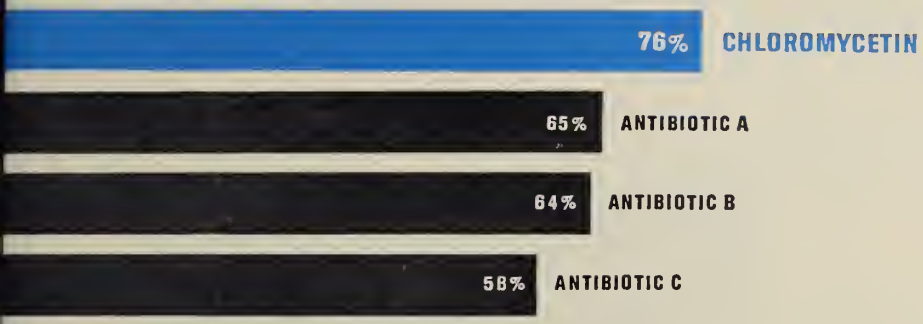
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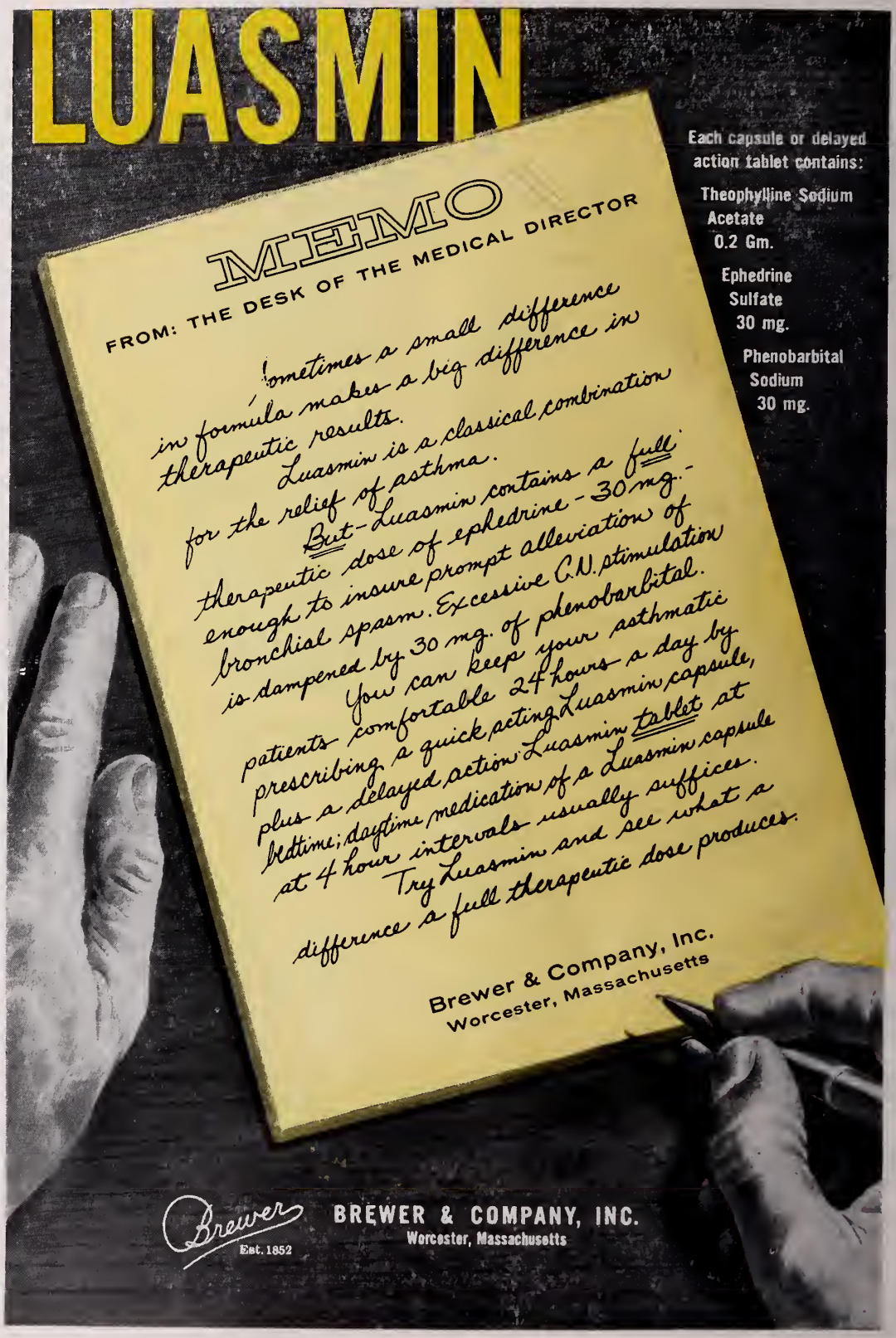
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Sometimes a small difference in formula makes a big difference in therapeutic results.
Luasmin is a classical combination for the relief of asthma.
But - Luasmin contains a full therapeutic dose of ephedrine - 30 mg. - enough to insure prompt alleviation of bronchial spasm. Excessive C.N.S. stimulation is dampened by 30 mg. of phenobarbital.
You can keep your asthmatic patients comfortable 24 hours a day by prescribing a quick acting Luasmin capsule, plus a delayed action Luasmin tablet at bedtime; daytime medication of a Luasmin capsule at 4 hour intervals usually suffices.
Try Luasmin and see what a difference a full therapeutic dose produces.
Brewer & Company, Inc.
Worcester, Massachusetts
Each capsule or delayed action tablet contains:
Theophylline Sodium Acetate 0.2 Gm.
Ephedrine Sulfate 30 mg.
Phenobarbital Sodium 30 mg.
Brewer
Est. 1852
BREWER & COMPANY, INC.
Worcester, Massachusetts

SPEED



DURATION



IN *ORAL* CONTROL OF PAIN

ACTS FASTER—usually within 5-15 minutes. **LASTS LONGER**—usually 6 hours or more. **MORE THOROUGH RELIEF**—permits uninterrupted sleep through the night. **RARELY CONSTIPATES**—excellent for chronic or bedridden patients.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

Also available — for greater flexibility in dosage — PERCODAN®-DEMI: The PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

Endo®

Literature? Write
ENDO LABORATORIES
Richmond Hill 18, New York

Percodan® *Tablets*

Salts of Dihydrohydroxycodeinone and Homatropine, plus APC

FOR PAIN

*U.S. Pat. 2,628,185



to prevent
the sequelae
of u.r.i. ...
and relieve the
symptom complex

ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Sinusitis, otitis, tonsillitis, adenitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.(1) To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline HCl (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP, caffeine-free.

(1) Estimate based on epidemiologic study by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122, Jan. 1933.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



no irritating crystals[1] · uniform concentration in each drop[2]

STERILE OPHTHALMIC SOLUTION

NEO-HYDELTRASOL®

PREDNISOLONE 21-PHOSPHATE-NEOMYCIN SULFATE

2,000 TIMES MORE SOLUBLE THAN PREDNISOLONE OR HYDROCORTISONE

"The solution of prednisolone has the advantage over the suspension in that no crystalline residue is left in the patient's cul-de-sac or in his lashes . . . . The other advantage is that the patient does not have to shake the drops and is therefore sure of receiving a consistent dosage in each drop."[2]

1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

supplied: 0.5% Sterile Ophthalmic Solution NEO-HYDELTRASOL (with neomycin sulfate) and 0.5% Sterile Ophthalmic Solution HYDELTRASOL. In 5 cc. and 2.5 cc dropper vials. Also available as 0.25% Ophthalmic Ointment NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL. In 3.5 Gm. tubes.

HYDELTRASOL and NEO-HYDELTRASOL are trademarks of Merck & Co., Inc.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., Philadelphia 1, Pa.

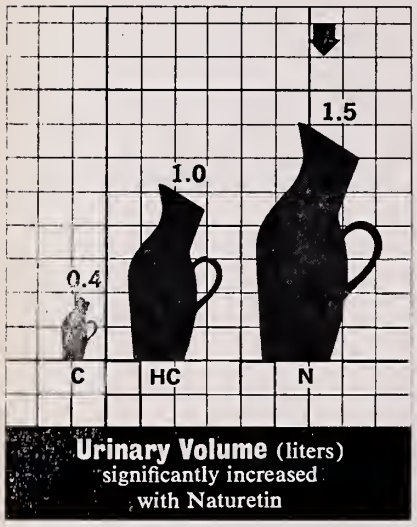
more closely approaches the ideal diuretic

Naturetin

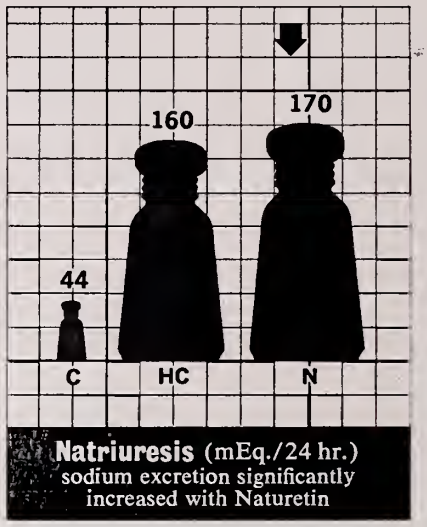
Squibb Benzydroflumethiazide

"When compared to other members of this heterocyclic gr
of compounds, this drug [NATURETIN] shows a significantly
creased natriuresis and decreased loss of potassium and bi
bonate. In this respect it more closely approaches a natural
'ideal diuretic.' It is effective upon continuous administration
causes no significant serum biochemical changes. It is effec
in a wide variety of edematous and hypertensive states
represents a significant advance in diuretic therapy." *Ford, R
Pharmacological observations on a more potent benzothiadia
diuretic; accepted for publication by the American Heart Jour*

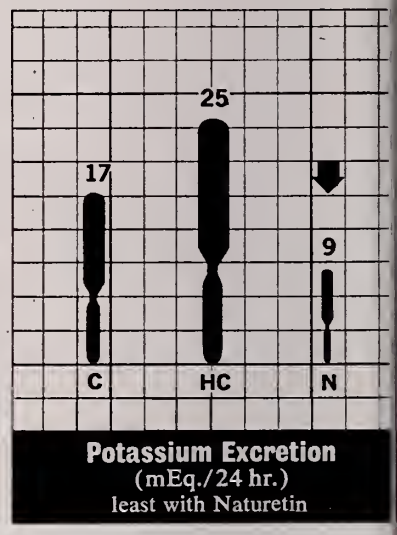
Comparison of electrolyte excretion pattern for the 24 hours followin typical doses of chlorothiazide, hydrochlorothiazide, and Naturetin



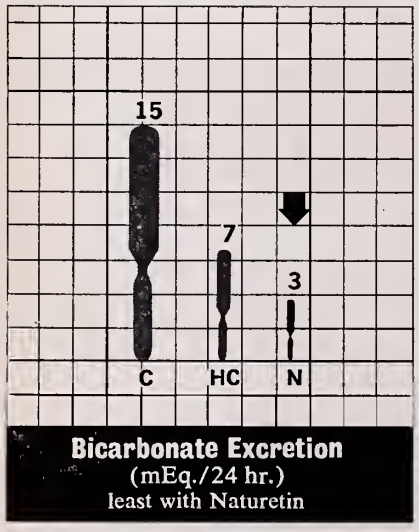
Urinary Volume (liters)
significantly increased with Naturetin



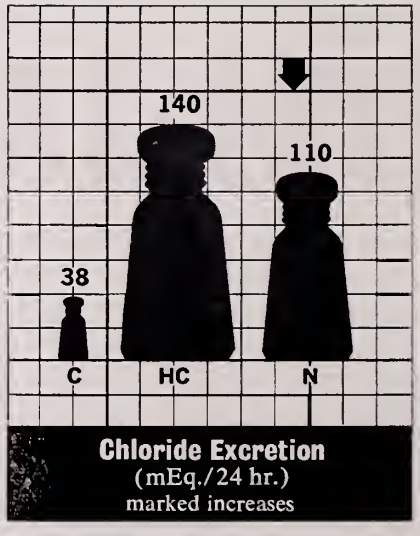
Natriuresis (mEq./24 hr.)
sodium excretion significantly increased with Naturetin



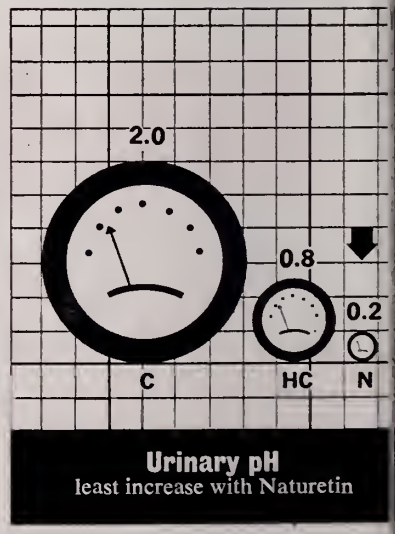
Potassium Excretion
(mEq./24 hr.)
least with Naturetin



Bicarbonate Excretion
(mEq./24 hr.)
least with Naturetin



Chloride Excretion
(mEq./24 hr.)
marked increases



Urinary pH
least increase with Naturetin

Typical Doses: Chlorothiazide – 1,000 mg.; Hydrochlorothiazide – 50 mg.; Naturetin (Benzydroflumethiazide) – 5 mg.

1. Adapted from: Ford, R. V., Squibb Clin. Res. Notes 2:1 (Dec.) 195

A single 5 mg. tablet once a day provides all these advantages[2]

- prolonged action — in excess of 18 hours
- convenient once-a-day dosage
- low daily dosage — more economical for the patient
- no significant alteration in normal electrolyte excretion pattern
- repetitively effective as a diuretic and antihypertensive
- greater potency mg. for mg.—more than 100 times as potent as chlorothiazide
- potency maintained with continued administration
- low toxicity — few side effects — low salt diets not necessary
- comparative studies with chlorothiazide, hydrochlorothiazide, and Naturetin disclose that smallest doses of Naturetin produce greater weight loss per day
- in hypertension, Naturetin, alone or in combination with other antihypertensives, produces significant decreases in mean blood pressure and other favorable clinical effects
- purpura and agranulocytosis not observed
- allergic reactions rarely observed

[2]Reports (1959) to the Squibb Institute for Medical Research.

Naturētin —*Indications:* in control of edema when diuresis is required, in congestive heart failure, in the premenstrual syndrome, nephrosis and nephritis, cirrhosis with ascites, edema induced by drugs (certain steroids); in the management of hypertension, used alone, combined with Raudixin (Squibb Rauwolfia Serpentina Whole Root), or with other antihypertensive drugs, such as ganglionic blocking agents.

Contraindications: none, except in complete renal shutdown.

Precautions: when Naturetin is added to an antihypertensive regimen including hydralazine, veratrum, and/or ganglionic blocking agents, immediate reduction must be made in the dosage for all preparations; the dosage for ganglionic blocking agents must be decreased by 50% to avoid a precipitous drop in blood pressure. This also applies if these hypotensive drugs are added to an established Naturetin regimen . . . in hypochloremic alkalosis with or without hypokalemia . . . in cirrhotic patients or those on digitalis therapy when reductions in serum potassium are noted . . . in diabetic patients or those predisposed to diabetes . . . when increased uric acid concentrations are noted . . . when signs—leg or abdominal cramps, pruritus, paresthesia, rash—suggestive of hypersensitivity, are noted.

Naturētin —*Dosage: in edema,* average dose, 5 mg., once daily, preferably in the morning; to initiate therapy, up to 20 mg., once daily or in divided doses; for maintenance, 2.5 to 5.0 mg., daily in a single dose. *In hypertension:* suggested initial dose, 5 to 20 mg. daily; for maintenance, 2.5 to 15 mg. daily, depending on the individual response of the patient. When Naturetin is added to an antihypertensive regimen with other agents, lower maintenance doses of each drug should be used.

Naturētin —*Supplied:* tablets of 2.5 mg. and 5 mg. (scored).

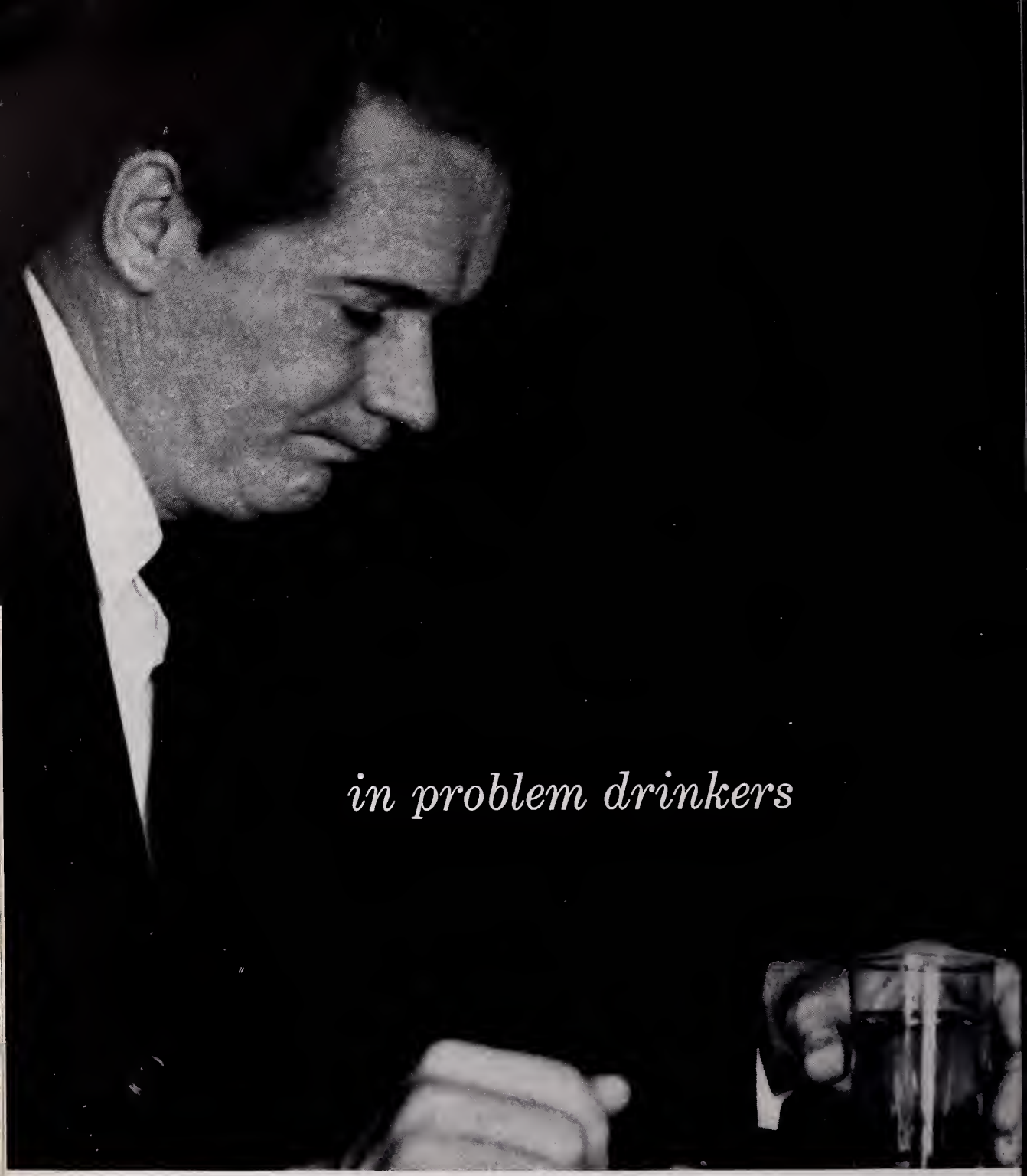
SQUIBB



Squibb Quality—the Priceless Ingredient

Rx Naturetin 5mg. Disp. #30 Sig: 1 each morning

'RAUDIXIN'® AND 'NATURETIN' ARE SQUIBB TRADEMARKS.



Vistaril®

hydroxyzine pamoate

dispels tension...

maintains tranquility

When tension and anxiety "drive him to drink," the problem drinker often finds that VISTARIL, by maintaining tranquility, restores perspective and helps him accept counsel more readily.

VISTARIL has demonstrated a wide margin of safety even in large doses (300-400 mg. daily) over prolonged periods. Clinical studies of alcoholism have shown that VISTARIL produces no significant depression of blood pressure, pulse rate, or respiration in chronic drinkers.

Capsules—25, 50, and 100 mg. *Parenteral Solution* (as the HCl)—25 mg. per cc., 10 cc. vials and 2 cc. Steraject® Cartridges; 50 mg. per cc., 2 cc. ampules.

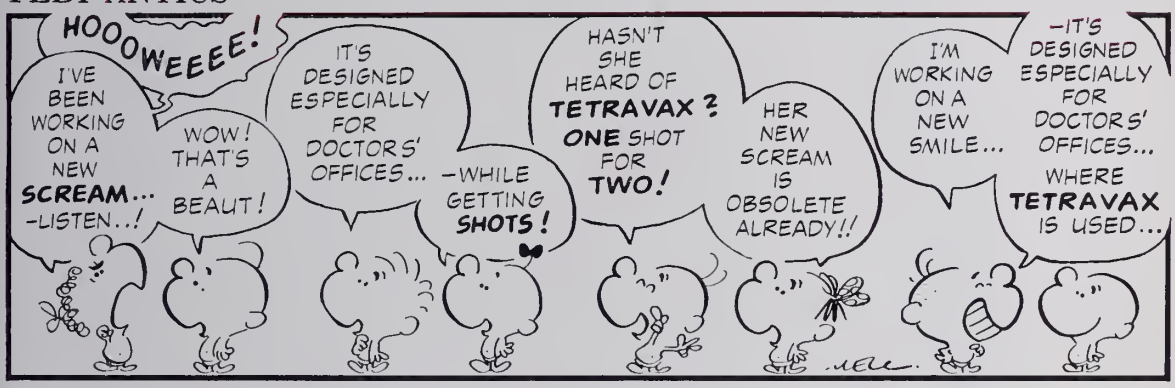
Professional literature available on request from the Medical Department, Pfizer Laboratories, Div. Chas. Pfizer & Co., Inc., Brooklyn 6, New York

Pfizer *Science for the world's well-being*®

FOR SIMULTANEOUS IMMUNIZATION AGAINST 4 DISEASES:

Poliomyelitis-Diphtheria-Pertussis-Tetanus

PEDI-ANTICS



TETRAVAX®

DIPHTHERIA AND TETANUS TOXOIDS WITH PERTUSSIS AND POLIOMYELITIS VACCINES

now you can immunize against more *diseases...with* fewer *injections*

Dose: 1 cc.
Supplied: 9 cc. vials in *clear plastic* cartons. Package circular and material in vial can be examined without damaging carton. Expiration date is on vial for checking even if carton is discarded.



For additional information, write Professional Services, Merck Sharp & Dohme, West Point, Pa.

TETRAVAX IS A TRADEMARK OF MERCK & CO., INC.

MSD MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

This is Panalba performance...





in pneumonia

. . . into a mixed culture of the three organisms commonly involved in pneumonia . . . *K. pneumoniae*, *Diplococcus pneumoniae*, and *Staphylococcus aureus* (in this case a resistant strain) . . . we introduce the five most frequently used antibiotics.

Twenty-four hours later (in this greatly enlarged photograph), note that only *one* of the five leading antibiotics has stopped *all* the organisms, including the resistant staph! This is Panalba.

In your next pneumonia patient . . . in *all* your patients with potentially-serious infections . . . provide this extra protection with your prescription :

Dosage—1 or 2 capsules 3 or 4 times a day.
Supplied—Capsules containing Panmycin phosphate equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin as novobiocin sodium, in bottles of 16 and 100.
Now available: new Panalba Half-Strength Capsules in bottles of 16 and 100.

Panalba*

(Panmycin* Phosphate plus Albamycin*)

The broad-spectrum antibiotic of *first* resort



Upjohn The Upjohn Company Kalamazoo, Michigan

*TRADEMARK, REG. U. S. PAT. OFF.

Each of the babies pictured on this page was borne by a mother with a *documented* previous history of true habitual abortion, who was treated with DELALUTIN during the pregnancy leading to this birth

LIVING PROOF OF FETAL SALVAGE WITH DELALUTIN

SQUIBB HYDROXYPROGESTERONE CAPROATE

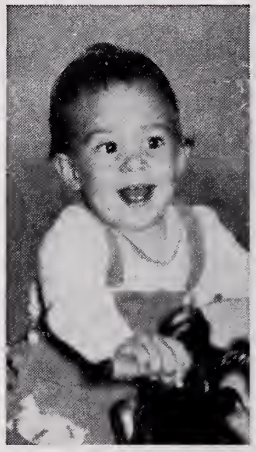
Improved Progestational Therapy



Garden City, N. Y.



Lincolnwood, Ill.



Skokie, Ill.



Denver, Colo.



Denver, Colo.



No. Massapequa, L. I., N. Y.



Roselle, Ill.



Seaford, N. Y.



Hartford, Conn.



East Williston, N. Y.



Norwich, Vt.

DELALUTIN offers these advantages over other progestational agents

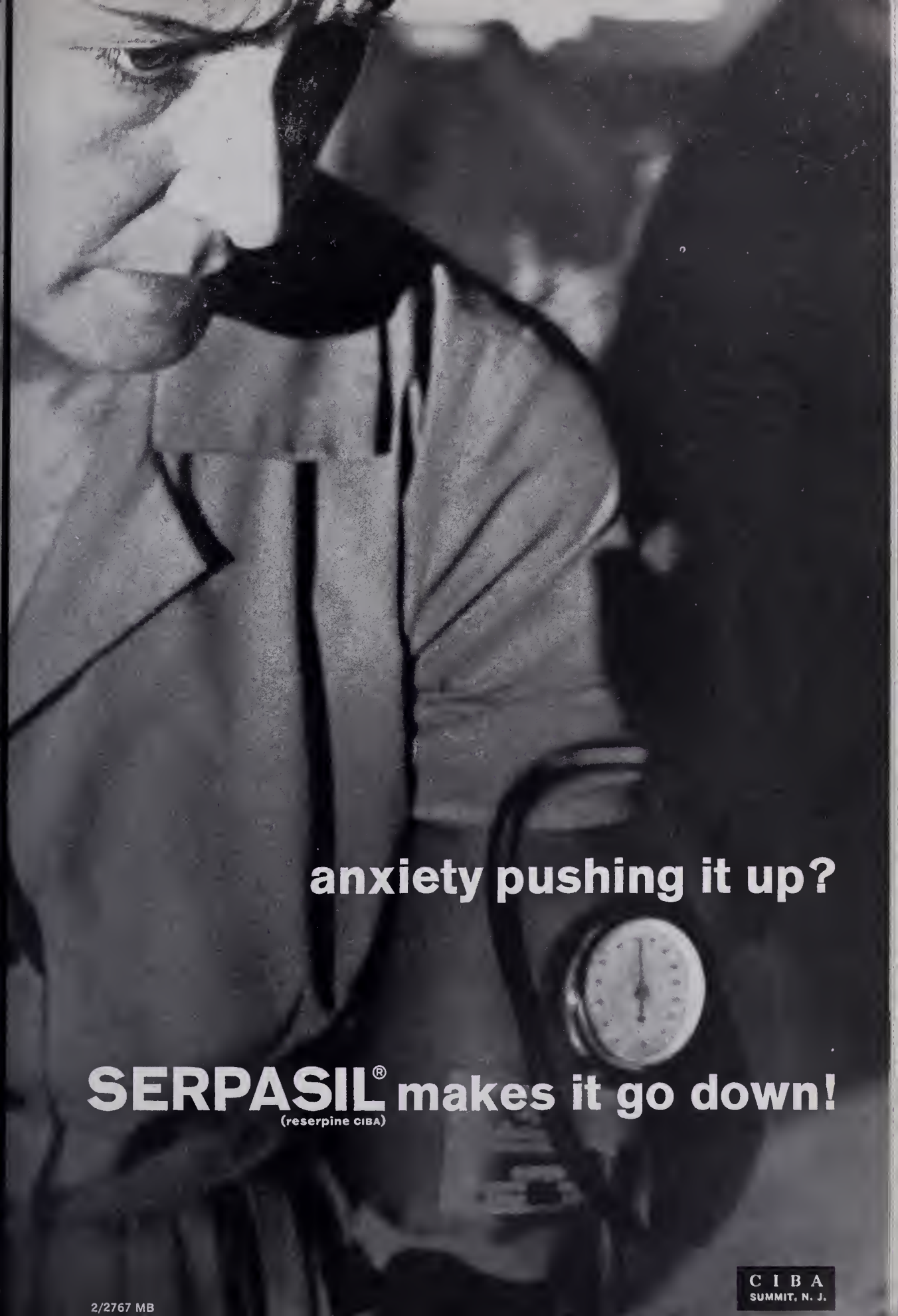
• long-acting sustained therapy • more effective in producing and maintaining a completely matured secretory endometrium • no androgenic effect • more concentrated solution requiring injection of less vehicle • unusually well-tolerated, even in large doses • fewer injections required • low viscosity makes administration easy

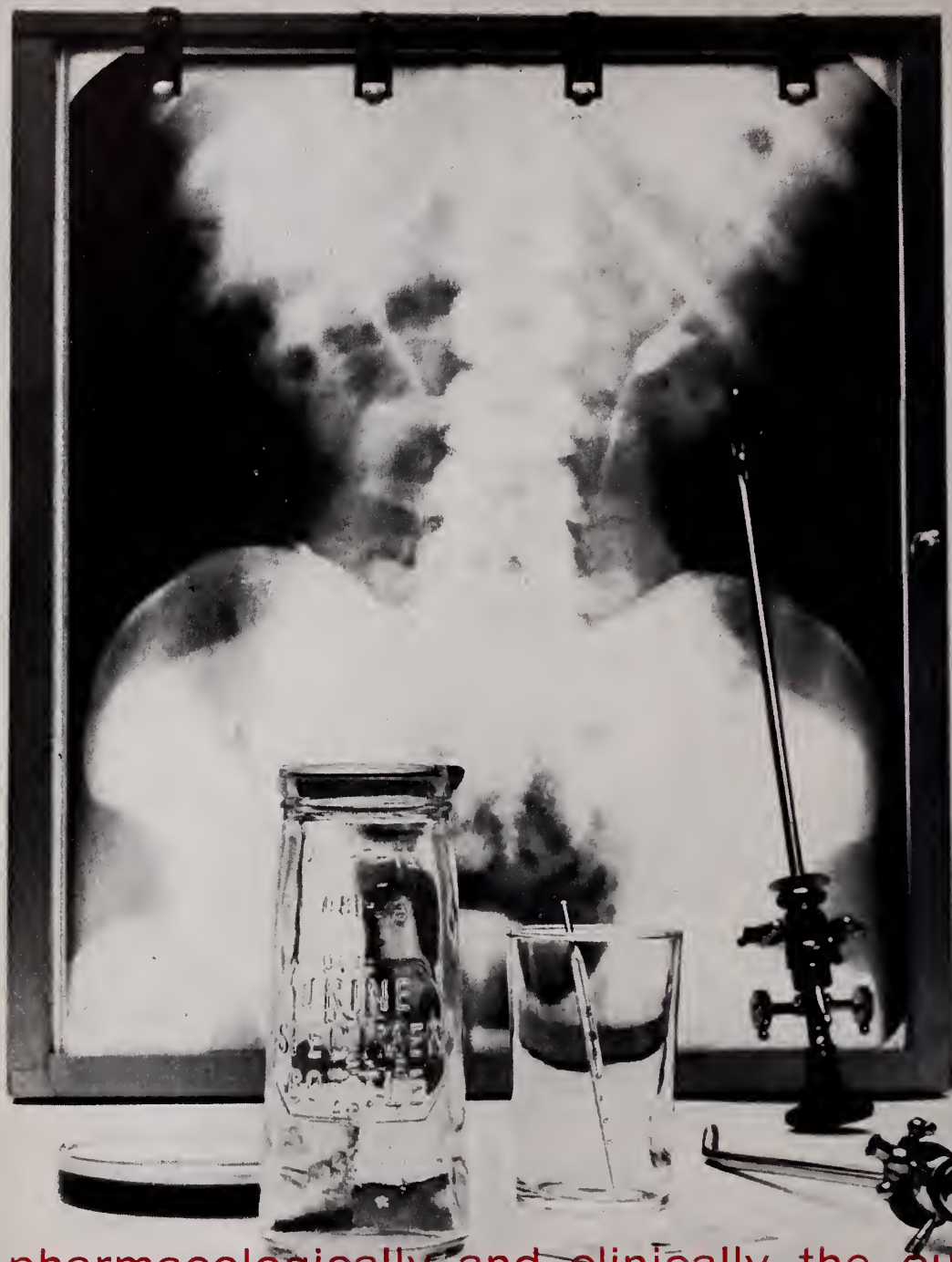
Complete information on administration and dosage is supplied in the package insert

Supply: Vials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in benzyl benzoate and sesame oil.

SQUIBB *Squibb Quality—The Priceless Ingredient*

'DELALUTIN'® IS A SQUIBB TRADEMARK


anxiety pushing it up?
SERPASIL®
(reserpine CIBA)
makes it go down!
CIBA
SUMMIT, N. J.
2/2767 MB



when sulfa is your plan of therapy.

pharmacologically and clinically the outstanding

Rapid peak attainment — for early control — KYNEX® Sulfamethoxypyridazine reaches peak plasma levels in 1 to 2 hours[1,2] . . . or approximately one-half the time of other once-a-day sulfas.[2] Uninterrupted control is then sustained over 24 hours with the single daily dose . . . through slow excretion without renal alteration.

High free levels — for dependable control — More efficient absorption delivers a higher percentage of sulfamethoxypyridazine — averaging 20 per cent greater at respective peaks than glucuronide-conversion sulfas.[2] Of the total circulating levels, 95 per cent remains in the fully active, unconjugated form even after 24 hours.[3]

Extremely low toxicity[4] . . . only 2.7 per cent incidence in recommended dosage — Typical of KYNEX relative safety, toxicity studies[5] in 223 patients showed TOTAL side effects (both subjective and objective) in only six cases, all temporary and rapidly reversed. Another evaluation[4] in 110 patients confirmed the near-absence of reactions when given at the recommended dosage. High solubility of both free and conjugated product[6] obviates renal complications. No crystalluria has been reported.

Successful against these organisms: streptococci, staphylococci, E. coli, A. aerogenes, paracolon bacillus, Gram-negative rods, pneumococci, diphtheroids, Gram-positive cocci and others.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annua 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.

KYNEX is your drug of choice



once-a-day sulfa . . .

NOTE: Investigators note a tendency of some patients to misinterpret dosage instructions and take KYNEX on the familiar q.i.d. schedule. Since one KYNEX tablet is equivalent to eight to twelve tablets of other sulfas; even moderate overdosage may produce side effects. Thus, the single dose schedule must be stressed to the patient.

KYNEX Tablets, 0.5 Gm., bottles of 24 and 100. Dosage: Adults, 0.5 Gm. (1 tablet) daily, following an initial first day dose of 1 Gm. (2 tablets).

KYNEX Acetyl Pediatric Suspension, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.). Bottles of 4 and 16 fl. oz. Recommended Dosage: Children under 80 lbs.: 1 teaspoonful (250 mg.) for each 20 lb. body weight, the first day, and ½ teaspoonful per 20 lb. per day thereafter. For children 80 lbs. and over: 4 teaspoonfuls (1.0 Gm.) initially and 2 teaspoonfuls daily thereafter. Give immediately after a meal.

KYNEX®

Sulfamethoxypyridazine Lederle

NEW—for acute G.U. infection AZO-KYNEX® Phenylazodiaminopyridine HCl—Sulfamethoxypyridazine Tablets, contains 125 mg. KYNEX in the shell with 150 mg. phenylazodiaminopyridine HCl in the core. Dosage: 2 tablets q.i.d. the first day; 1 tablet q.i.d. thereafter.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

Butazolidin®

brand of phenylbutazone

in arthritis and allied disorders

proved by a decade of experience

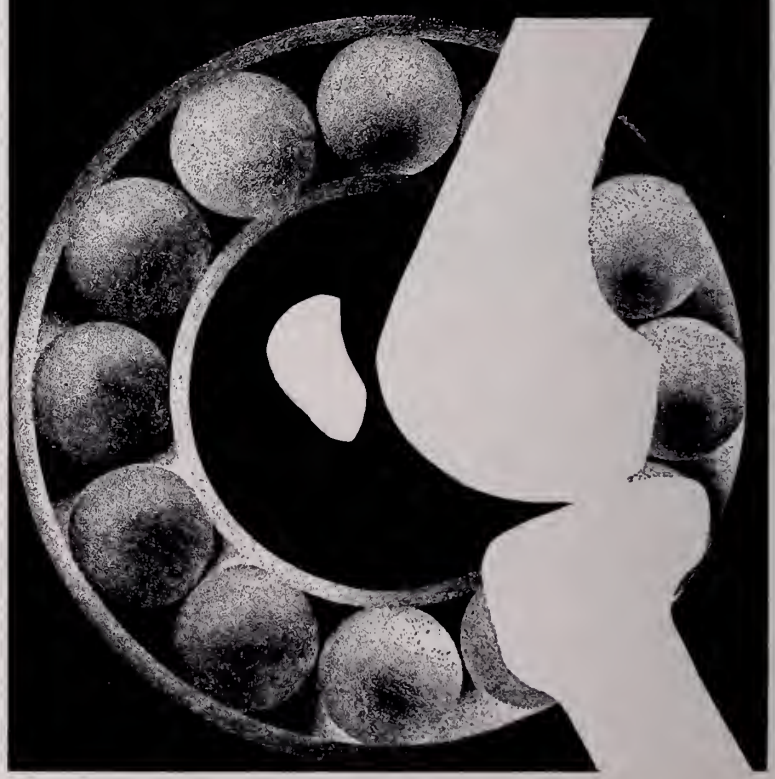
Ten years of experience in countless cases—more than 1700 published reports—have now established the eminence of Butazolidin among the potent non-hormonal antiarthritic agents.

Repeatedly it has been demonstrated that Butazolidin:
Within 24 to 72 hours produces striking relief of pain.
Within 5 to 10 days affords a marked improvement in mobility and a significant subsidence of inflammation with reduction of swelling and absorption of effusion.

Even when administered over months or years Butazolidin does not provoke tolerance nor produce signs of hormonal imbalance.

Butazolidin® brand of phenylbutazone: Red-coated tablets of 100 mg.
Butazolidin® Alka: Capsules containing Butazolidin® 100 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

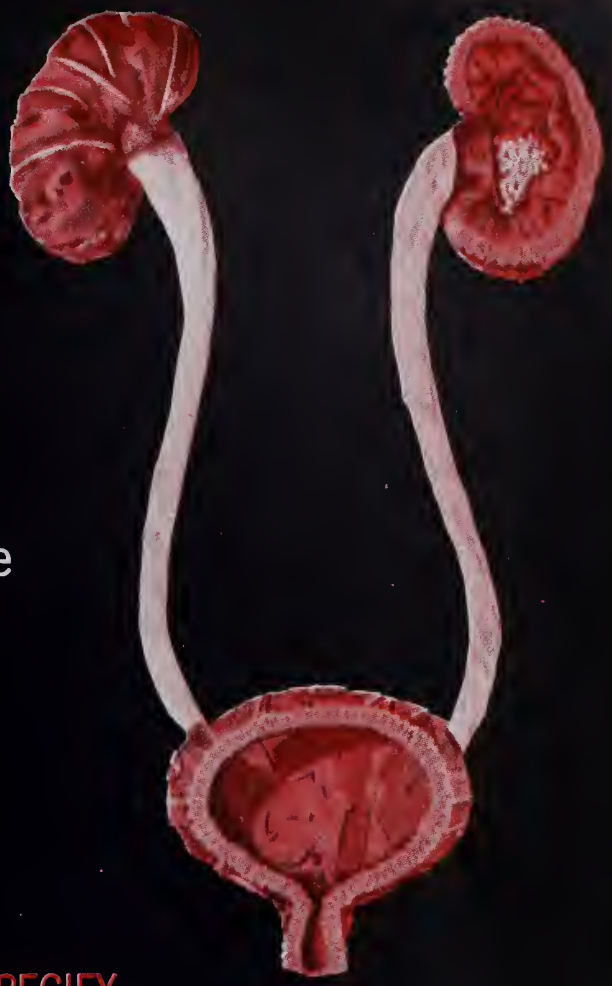
Geigy, Ardsley, New York



Geigy

BU 7-60

Just a "simple" case of cystitis may be the precursor of pyelonephritis[1]— or may actually be the first evidence of a pre-existing pyelonephritic process.[2]



WHEN TREATING CYSTITIS—SPECIFY

FURADANTIN®

brand of nitrofurantoin

FIRST

to ensure rapid control of infection throughout the urogenital system

Rapid bactericidal action against a wide range of gram-positive and gram-negative bacteria including organisms such as staphylococci, Proteus and certain strains of Pseudomonas, resistant to other agents ■ actively excreted by the tubule cells in addition to glomerular filtration ■ negligible development of bacterial resistance after 8 years of extensive clinical use ■ excellent tolerance—nontoxic to kidneys, liver and blood-forming organs ■ safe for long-term administration

AVERAGE FURADANTIN ADULT DOSAGE: 100 mg. q.i.d. with meals and with food or milk on retiring. Supplied: Tablets, 50 and 100 mg.; Oral Suspension, 25 mg. per 5 cc. tsp.

REFERENCES: 1. Campbell, M. F.: Principles of Urology, Philadelphia, W. B. Saunders Co., 1957. 2. Colby, F. H.: Essential Urology, Baltimore, The Williams & Wilkins Co., 1953.

NITROFURANS—a unique class of antimicrobials—neither antibiotics nor sulfonamides

EATON LABORATORIES, NORWICH, NEW YORK

The first synthetic penicillin available for general clinical use

FOR YOUR NEXT PATIENT WHERE PENICILLIN IS INDICAT

SYN

PEAK BLOOD LEVELS TWICE AS HIGH AS WITH POTASSIUM PENICILLIN V

ORAL ROUTE PROVIDES HIGHER PEAK BLOOD LEVELS THAN INTRAMUSCULAR PENICILLIN G

IMPROVED ANTIBIOTIC ACTION FROM ISOMERIC COMPLEMENTARIT





ONSIDER THESE 6 IMPORTANT THERAPEUTIC ATTRIBUTES OF



TM

POTASSIUM PENICILLIN-152

NTIBIOTIC CTIVITY IRECTLY ROPORTIONAL O ORAL DOSE

REDUCED RATE OF INACTIVATION BY STAPH PENICILLINASE

MANY STAPH STRAINS MORE SENSITIVE TO SYNCILLIN IN VITRO

BRISTOL



FOR HIGHLY EFFECTIVE THERAPY OF THE LARGE VARIETY OF INFECTIONS CAUSED BY SUSCEPTIBLE PATHOGENS... NEW

SYN

Significance of complementary action of isomers in SYNCILLIN

The antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than that of either of its two component isomers alone against many important pathogens, including some penicillin-resistant staphylococci. This phenomenon has been described as *Isomeric Complementarity*.

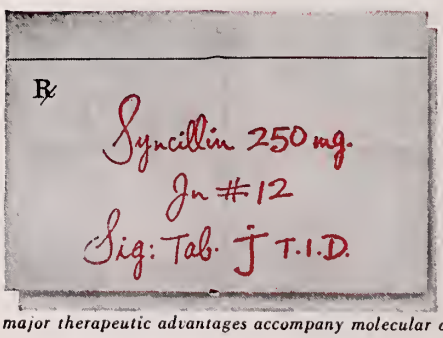
Significance of higher blood levels with SYNCILLIN

Higher blood levels may be of value with organisms of only moderate penicillin sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition, these higher levels may be necessary where there is infection in areas with a poor blood supply. Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue. Also, antibiotic activity of SYNCILLIN is directly proportional to oral dosage. Increasing the dosage may, therefore, enhance the drug's effectiveness in certain cases.

Efficacy of SYNCILLIN against staphylococci and other resistant organisms

Studies have shown that SYNCILLIN is effective *in vitro* against 60 to 75% of hospital "staph" strains, while penicillin G and penicillin V are now effective against only 30 to 50%.[1, 2] Therefore, if clinical judgment indicates the use of penicillin, SYNCILLIN would be expected to be the most effective. However, since some strains are still resistant to SYNCILLIN as well as to the other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment.

There have recently been reports of decreased efficacy of penicillin in streptococcal[3] and gonococcal[4, 5] infections. The emergence of penicillin-resistant gonococci appears to be associated with an increase in the incidence of gonorrhea all over the world. When a less sensitive strain is encountered the higher blood levels produced by SYNCILLIN may be most helpful.



major therapeutic advantages accompany molecular asymmetry

[LLIN™



Relation of intermittent high blood levels of SYNCILLIN to antibacterial efficacy

SYNCILLIN, like all clinically available penicillins, is bactericidal. Periodic high blood concentrations may be sufficient to permit complete eradication of sensitive pathogens. According to Eagle,[6] "Soon after penicillin attains effective concentrations, the bacteria cease multiplying; and the bacteriostatic effect persists for a number of hours after penicillin has fallen to concentrations that are wholly ineffective. . . . The therapeutic significance of this postpenicillin recovery period is enhanced by the fact that the recovering bacteria, damaged but not killed by the previous exposure to penicillin, are abnormally susceptible to the host defenses. In consequence, the bactericidal process *in vivo* continues for many hours after the drug itself has fallen to ineffective concentrations."

Reduced rate of inactivation of SYNCILLIN by staph penicillinase

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms. SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V or penicillin G. Penicillinase from *B. cereus* likewise inactivates SYNCILLIN less rapidly than penicillin V or G.

Indications: SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins. SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage: 125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals. Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions: At the present time it is not possible to draw definite conclusions regarding the incidence of allergenicity to SYNCILLIN or its cross-allergenicity with natural penicillins. *Therefore, the usual precautions for oral penicillin therapy should always be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care. Administration of oral penicillin, in rare instances, may provoke acute anaphylaxis, particularly in penicillin-sensitive individuals.

Diarrhea has been reported occasionally following heavy dosage. If this occurs, lengthen the interval between dosages.

If superinfection occurs during therapy, appropriate measures should be taken. Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply: 125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

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"I feel tired even after a full night's sleep."

Restores normal vitality in

emotional fatigue

Deprol relieves undue tiredness, apathy and depressed moods as it calms anxiety – without the risk of liver damage or extrapyramidal symptoms frequently reported with energizers or phenothiazines.

Emotional or nervous fatigue—undue tiredness, apathy, lethargy and listlessness—cuts sharply into the patient's usual physical and mental productivity. It is one of the most common conditions seen in every medical practice. Untreated, emotional fatigue may mushroom into a depressive episode, anxiety state, chronic fatigue or a mixture of these disorders.

Deprol acts fast to relieve emotional fatigue. It overcomes tiredness and lethargy, apathy and listlessness, thus restoring normal vitality and interest before the fatigue deepens. On Deprol, improvement is achieved without producing liver toxicity, hypotension, psychotic reactions, changes in sexual function or Parkinson-like reactions associated with energizers or phenothiazines.

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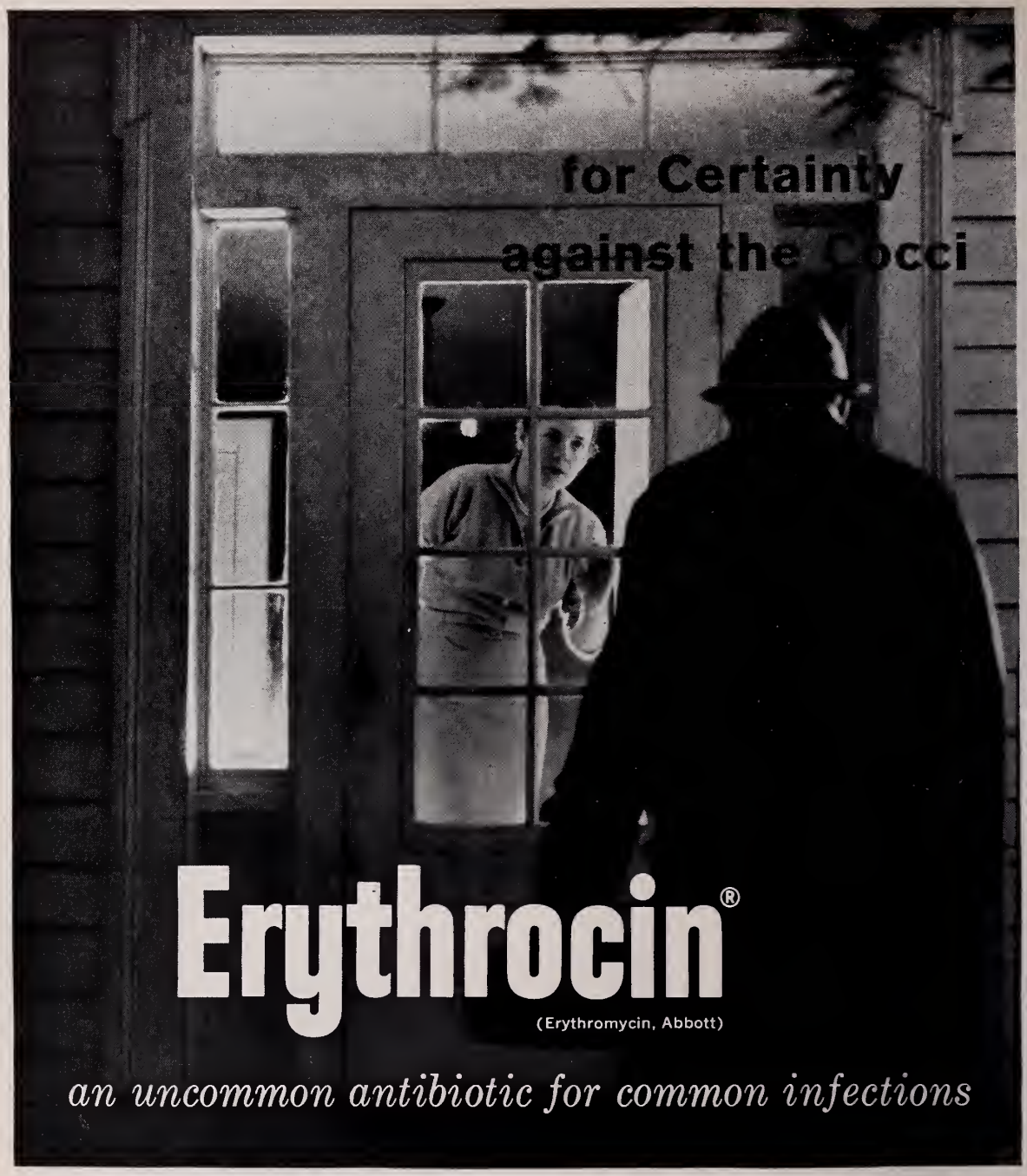


▲Deprol▲®

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d.
Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.
Supplied: Bottles of 50 light-pink, scored tablets.

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A MAJOR CONTRIBUTION TO ANTI-INFECTIVE THERAPY

PROPERTIES:

Greater inhibitory action ...lower daily intake than other tetracyclines

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Broad-spectrum control ...with far less antibiotic

Activity levels of DECLOMYCIN Demethylchlortetracycline are higher than those of previous broad-spectrum antibiotics. Hardier strains of various organisms appear to be somewhat more responsive.[4] Apparently some strains of Pseudomonas, Proteus and *A. aerogenes,* frequently refractory to therapy, are sensitive to DECLOMYCIN.[7,23,25,26]

DECLO

Sustained peak activity ...greater security of control

Prolonged retention and compatibility of DECLOMYCIN with body fluids provides peak activity between doses.[15,17,18,27] Inhibition of bacteria is more constant.

24-48 hours extra activity...protection against relapse

DECLOMYCIN maintains effective antimicrobial action for one to two days after stopping dosage.[7,14] Resurgence of a few viable pathogens, with relapse...and low patient defense against secondary bacterial invasion during the first post-therapy days . . . are largely offset.

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PERFORMANCE

Susceptibility Tests

Roberts, M. S., *et al.*[25]
New York, N. Y.

Pre-treatment sensitivity tests in 75 genitourinary patients showed DECLOMYCIN Demethylchlortetracycline to be superior against the large majority of organisms and in no instance inferior to tetracycline. DECLOMYCIN apparently has more effective coverage... several strains of *Proteus* and *A. aerogenes* responded.

Tolerance & Toxicity

Boger, W. P., and Gavin, J. J.[2]
Norristown, Pa.

Administration of the recommended 600 mg. (4 capsules) daily for 30 days to a small group of elderly patients revealed no hematologic, hepatic and urinary alteration or other abnormal finding. No clinical side effects were observed.

Gonococcal Infection

Marmell, M., and Prigot, A.[20]
New York, N. Y.

All except two of 63 patients with acute gonorrhea responded promptly to therapy with DECLOMYCIN. Fifteen received 250 mg. q.i.d. for one day, the remainder received 600 or 750 mg. in divided doses over one or two days. No side effects.

General Medicine

Lichter, E. A., and Sobel, S.[19]
Chicago, Ill.

One hundred and sixty-nine patients with various infections showed generally equivalent response to four dosage regimens, including the recommended level. Of 29 pneumococcal pneumonias, all recovered with 15 afebrile in 48 hours or less – except a few patients with preterminal underlying disease. All 42 scarlet fever patients recovered with 32 afebrile in 48 hours or less. Other patients also responded satisfactorily with few exceptions. No blood, liver or kidney toxicity found. G.I. side effects occurred in only 2 per cent at the recommended dosage, or less, and were easily reversible.

Respiratory Infection

Perry, D. M., *et al.*[22]
Seattle, Wash.

Good or fair response in 24 of 30 cases of acute bacterial pneumonia, and in all of six cases of acute bronchitis. Side effects occurred at higher dosage but were uniformly absent when dosage was limited to 600 mg. per day.

Various Infections

Finland, M., *et al.*[7]
Boston, Mass.

Eighty patients with various infections were treated with DECLOMYCIN Demethylchlortetracycline and an equal number with tetracycline. Therapeutic response was indistinguishable between the two groups. However, DECLOMYCIN Demethylchlortetracycline dosage was much lower (50 to 60 per cent of that of tetracycline.) In addition, incidence of side effects with demethylchlortetracycline was only half that experienced with tetracycline.

Pyelonephritis

Vineyard, J. P., *et al.*[29]
Dallas, Tex.

Therapy with DECLOMYCIN was successful in 12 of 13 patients with pyelonephritis. Sterile cultures were obtained in nine patients within six to 14 days. Among the organisms suppressed were strains of *A. aerogenes, E. coli* and paracolon bacillus. In most cases, DECLOMYCIN was used jointly with another antibiotic.

Soft Tissue Infection

Prigot, A., *et al.*[24]
New York, N. Y.

DECLOMYCIN was used alone or auxiliary to surgical measures in 150 cases of acute soft tissue infection, mostly ambulatory. Full resolution of infection was achieved in all cases, average length of treatment being six days. Dosage was 600 or 750 mg. daily. Side effects consisted of transitory G.I. disturbances in three cases.

DECLO

Urinary Infection

Trafton, H. M., and Lind, H. E.[28]
Brookline, Mass.

Clinical response was favorable in a majority of 50 cases of urinary tract infections with relief of symptoms, elimination, or marked reduction, of pyuria and with urine sterilization in some. DECLOMYCIN Demethylchlortetracycline was administered in one-half to one-third the daily milligram level of related antibiotics, for 8 days.

No significant diarrhea occurred in any case although mild nausea and upper G.I. symptoms were fairly common. Phototoxicity occurred in six cases.

Antibiotic-Resistant Infections

Compilation of reports of 210 clinical investigators.[23]

In 570 treated for a great variety of infections, DECLOMYCIN was successful in resolving infection or in effecting marked improvement in 81 per cent, after failure of other antibiotics.

Pediatric Infection

Fujii, R., *et al.*[9]
Tokyo, Japan

Therapeutic results, elicited in 309 pediatric patients with average daily dosage of 15 mg./kg., were equal to those produced by 30 mg./kg. of buffered tetracycline preparations. Satisfactory results were obtained in 75 per cent. No appreciable side effects when 15 mg./kg./day dosage was not exceeded.

Pediatric Infection

Hall, T. N.[12]
San Francisco, Cal.

All eight cases of ophthalmic, respiratory or otic infection responded to four to twelve days of DECLOMYCIN therapy (5 recovered, 2 greatly improved, 1 improved). One skin reaction, in a case receiving the higher trial dosage of 7 mg./lb. daily, occurred.

Pneumonias

Duke, C. J., *et al.*[5]
Washington, D. C.

Results were satisfactory in all 32 cases of acute bacterial penumonia, excepting for two caused by non-susceptible organisms. Over half had been complicated by pleural, suppurative, bronchial, or underlying structural lung problems. Dosage was low. No toxicity found. Acceptance and toleration were excellent.

Intestinal & Respiratory Infection

Hartman, S. A.[13]
Sherman Oaks, Cal.

Six cases of g.i. infection (diverticulitis, ileitis, colitis) responded in three to eight days on the lower milligram intake...even after failure in most with sulfa, neomycin or penicillin-streptomycin. Complete recovery was gained in 5 respiratory cases on a shorter schedule; another withdrew with occurrence of thrush. No other side effects were reported.

Respiratory Infection

Feingold, B. F.[6]
San Francisco, Cal.

All 13 upper or lower respiratory infections demonstrated very good response in 2-3 days on recommended dosage. No side effects were reported.

Various Infections

Compilation of reports of 210 clinical investigators.[23]

Of 1,904 patients with adequate follow-up treated for a wide diversity of infections, 87 per cent were reported as cured or improved. Most patients received one 150 mg. tablet every 6 hours. Therapy usually was for three to eight days. Side effects, mostly referable to the gastrointestinal tract, occurred in 200 patients.

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PERFORMANCE *(continued)*

Respiratory Infection & Others

Gates, G. E.[11]
South Bend, Ind.

Of 65 cases, predominantly respiratory infections, but including some of cystitis and cellulitis, 50 had a good response, 12 were fair and three were failures. One of the failures was a case of chronic ulcerative colitis and two were respiratory infections. The only complication was a slight vulvular pruritus and burning tongue occurring near the end of a week's treatment of residual pneumonitis.

Pustular Dermatoses

Kanof, N. B., and Blau, S.[16]
New York, N. Y.

Eighty-five per cent of 67 patients responded with excellent or good results on a DECLOMYCIN schedule of one 150 mg. capsule q.i.d. for two to twelve weeks. Three poor responses were related to highly resistant organisms. No pruritus or drug eruptions developed. Only four cases showed nausea or diarrhea in the long therapeutic course.

Surgical Infection

Floyd, R. D., and Anlyan, W. G.[8]
Durham, N. C.

Successful results were generally obtained in 60 patients given 600 mg. DECLOMYCIN daily (or slightly less) for five to 15 days. No infection developed in the clean or contaminated prophylaxis group. Most frank infections responded...including several refractory to previous antibiotics. No toxicity evidenced. Intestinal toleration was excellent.

Wound Infections & Others

Meyer, B. S.[21]
Birmingham, Ala.

Thirty-five cases, chiefly prophylactic, and some traumatic-surgical wound infections were treated usually on one capsule DECLOMYCIN q. 6 h. for two to eight days. Over 80 per cent responded, including one with Pseudomonas etiology. Minor itching or nausea occurred in two; prominent nausea developed in one on a q. 4 h. schedule.

Topical & Wound Infections

Stewart, J.[26]
New Orleans, La.

Of 21 patients followed, 15 completely recovered, four improved in four to 42 days on 600 mg. daily. Seven had not responded to various other therapies. One had *A. aerogenes* predominance, complicated by Proteus and *E. coli*. Cases were traumatic-surgical-topical infections with some respiratory. One questionable reaction of anemia was encountered.

Oral Infection

Arbour, E. F.[1]
New Orleans, La.

Of four patients treated, three responded to one capsule DECLOMYCIN q. 6 h. for three days. No change in one case of chronic proliferating periodontitis. No adverse reactions seen.

Brucellosis

Chávez, Max, G.[3]
Mexico, D. F.

All nine patients infected with *Brucella melitensis* were afebrile on fourth or fifth day of DECLOMYCIN therapy and asymptomatic within 15 days. Treatment lasted for 45 days. No relapses occurred. Hepatic, renal, or hematologic toxicity was not seen. Minor or occasional intestinal reactions in some cases did not require discontinuance.

DECLO

IMPORTANCE...

in the average patient – DECLOMYCIN reduces the possibility of gastrointestinal intolerance and increases the likelihood of an uneventful therapeutic course. Variants of an infecting organism are less likely to survive the high, sustained activity and post-dosage control. Minor or major reverses or "setbacks" during therapy may be avoided. Susceptibility to secondary infection when dosage is terminated is counteracted by the "extra-day" activity.

in mixed infections–DECLOMYCIN provides satisfactory control of conditions involving multiple pathogens. Since organisms vary in sensitivity at given antibiotic levels, the higher DECLOMYCIN activity tends to inhibit a greater proportion of the less susceptible strains. Remission and bacteriologic cure can thus progress at a faster pace.

in the absorption-deficient – The high activity/intake ratio of DECLOMYCIN provides a wider margin of security for those with disturbed or abnormal absorption or with underlying gastrointestinal dysfunction. Inhibitory levels remain more than adequate in most.

under adverse host conditions – In debility, malnutrition, neoplasm, diabetes, or other organic, chronic or underlying disease, DECLOMYCIN may be vital to successful resolution of infection. *Generally in geriatrics,* for the same reason, DECLOMYCIN should often be a broad-spectrum of choice.

if an occasional dose is missed – The sustained action of DECLOMYCIN protects against possible loss of control. In the sleeping patient, an occasional dose may be foregone without adverse effect, while benefits of such rest are gained. Arbitrary rejection of a dose by pediatric or geriatric patients...simple forgetfulness...or postponing a dose will not appreciably reduce antibiotic activity provided these do not occur frequently.

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CAPSULES, 150 mg., bottles of 16 and 100. *Dosage:* Average adult 1 capsule four times daily.

PEDIATRIC DROPS, 60 mg./cc. (custard flavor) in 10 cc. bottle with calibrated dropper. *Dosage:* 1-2 drops (3-6 mg.) per pound body weight per day—divided into 4 doses.

ORAL SUSPENSION, 75 mg./5 cc. teaspoonful (custard flavor) in 2 oz. bottle. *Dosage:* 3-6 mg./lb./day—divided in 4 doses.

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DESTROYS all vaginal pathogens on contact (even in presence of blood, pus, vaginal secretions). **PENETRATES** into vaginal rugae. **STOPS** discharge and pruritus, reduces malodor. **CLEARS** the vaginal tract without irritation or sensitization . . . has been used with considerable success even in difficult and refractory cases.[6]

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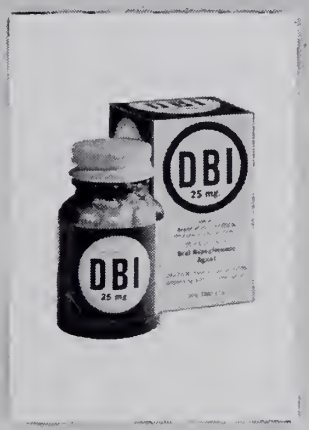



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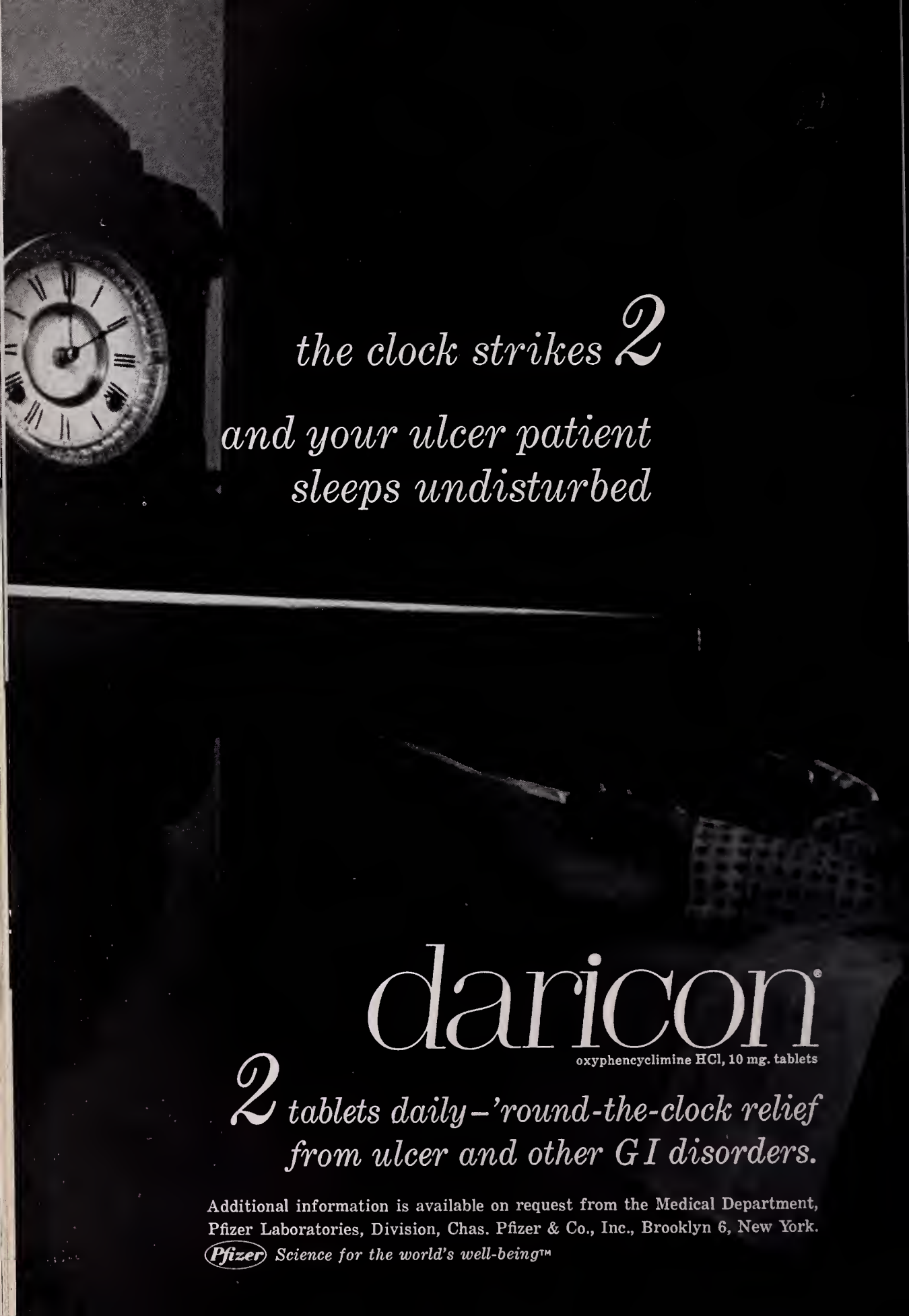
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myalgias
common cold
toothache
earache
dysmenorrhea
neuralgia
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minor surgery
post-partum pain
trauma
organic disease
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muscle spasm
colic
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fractures
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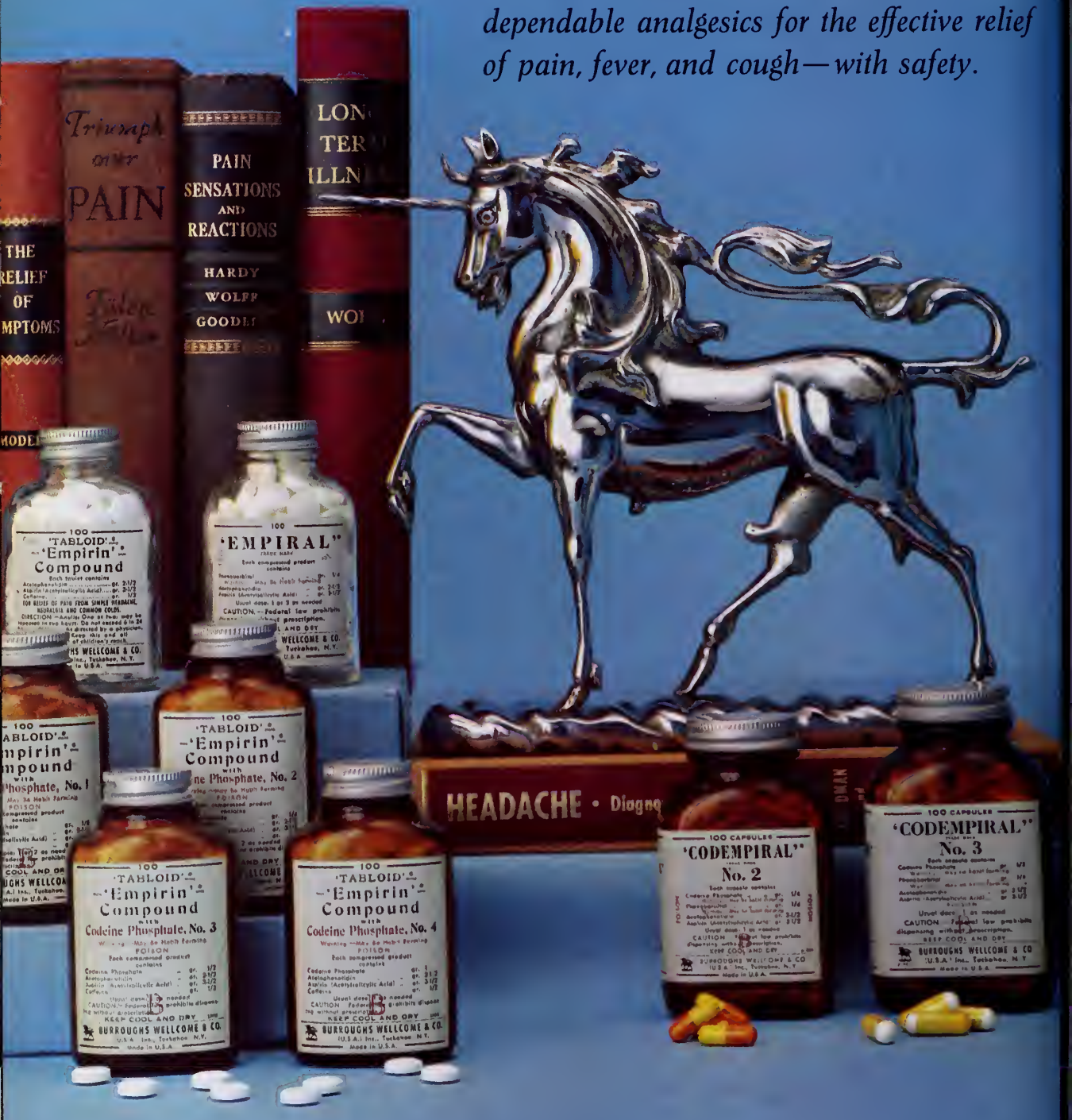
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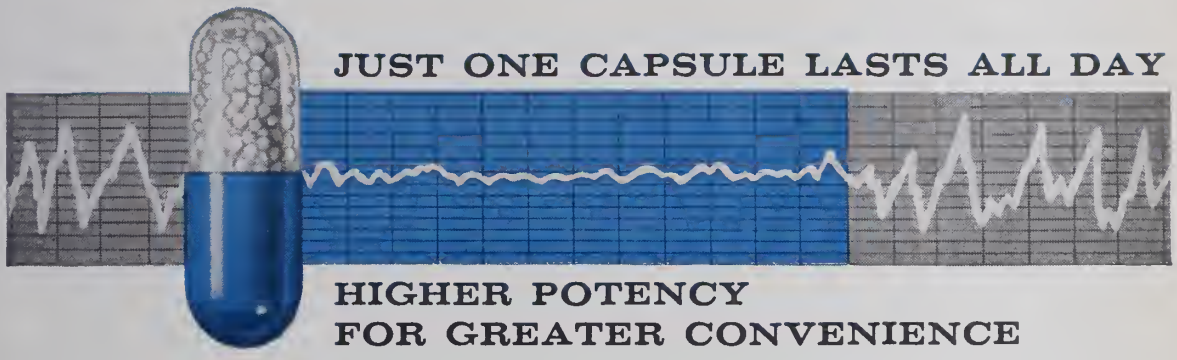
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Because of the infrequency of the disease in this age group, its sudden onset, the profusion of inconsistent presenting symptoms, and because the accompanying symptoms of anorexia and vomiting are also characteristic symptoms of many other ills of infancy.

Source: Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.: Diabetes *8*:289, 1959.

for those pediatric puzzlers..."A routine urinalysis and blood sugar should be done whenever the possibility of diagnosing diabetes is entertained."*

DIABETES MELLITUS AT AGES 1 TO 5

Order of Frequency of Presenting Symptoms in 110 Patients

Symptoms	No. of Patients	Per cent of total group
Polyuria	93	84.5
Polydipsia	89	81.0
Weight loss	47	42.7
Polyphagia	28	25.4
Anorexia	16	14.5
Lethargy	14	12.7
Enuresis	7	6.4
Vomiting	5	4.5
Irritability	3	2.7
"Craving for sweets"	3	2.7
"Sticky diaper"	3	2.7
"Strong odor to urine"	2	1.8
Glycosuria	2	1.8
Hypoglycemia	2	1.8
Personality change	1	0.9
Boils	1	0.9
Headache	1	0.9
Abdominal cramps	1	0.9

Adapted from Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.*

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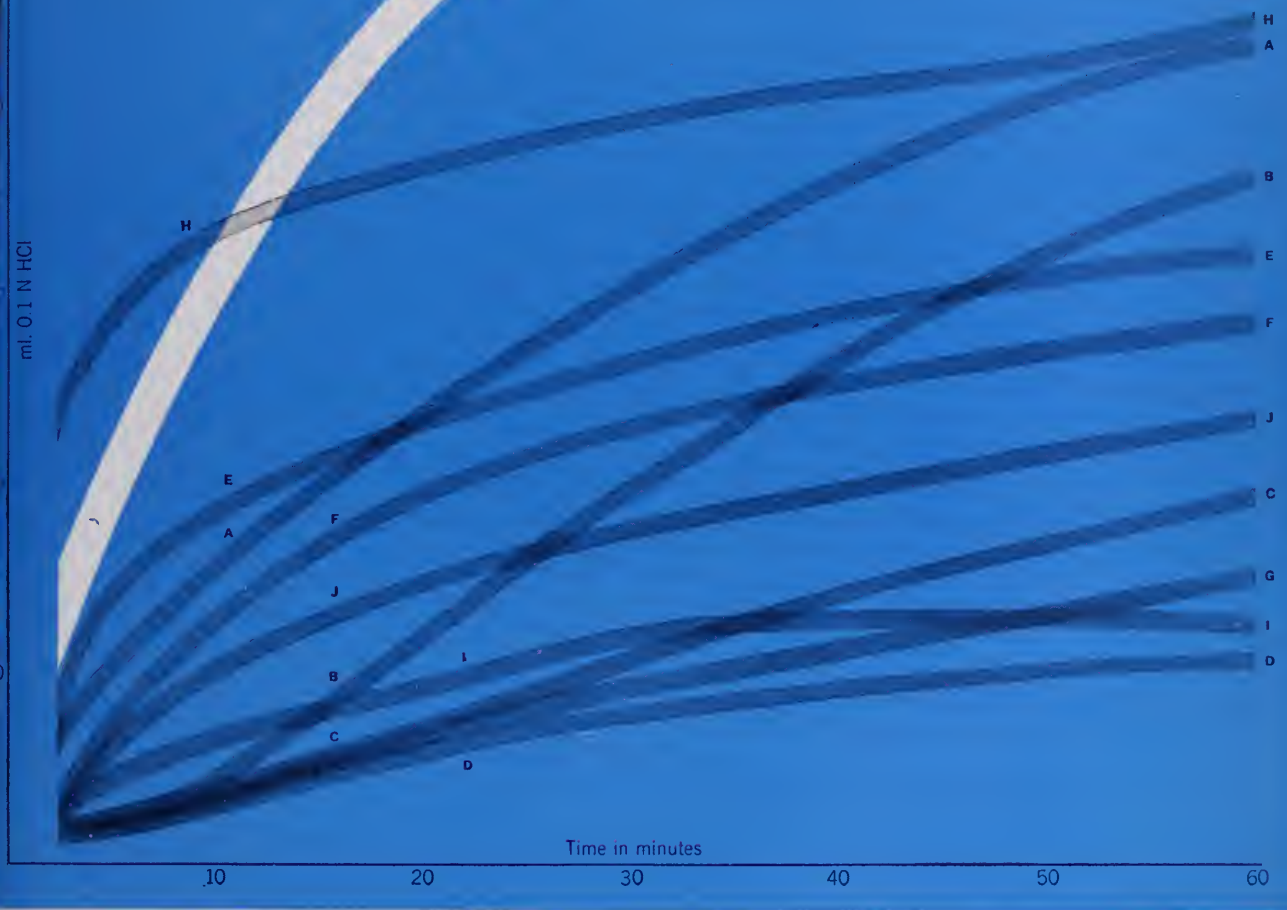
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Tablets were powdered and suspended in distilled water in a constant temperature container (37°C) equipped with mechanical stirrer and pH electrodes. Hydrochloric acid was added as needed to maintain pH at 3.5. The volume of acid required was recorded at frequent intervals for one hour.



GREATLY HEIGHTENED REACTIVITY to acid characterizes the action of New Creamalin Antacid Tablets.[1,2] They act faster and longer than other leading tablets and neutralize considerably more acid.[1] These tablets provide virtually the same effects as a liquid[2] with the convenience of a tablet. New Creamalin tablets give faster, greater and more prolonged relief.

NOT CONSTIPATING, New Creamalin Antacid Tablets will not produce "acid rebound" or alkalosis. They have a pleasant taste.

EACH NEW CREAMALIN ANTACID TABLET contains 320 mg. of specially processed, highly reactive, short polymer dried aluminum hydroxide gel (stabilized with hexitol), with 75 mg. of magnesium hydroxide.

Adult dosage: Gastric hyperacidity—2 to 4 tablets as necessary. Peptic ulcer or gastritis—2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed whole with water or milk, or allowed to dissolve in the mouth.

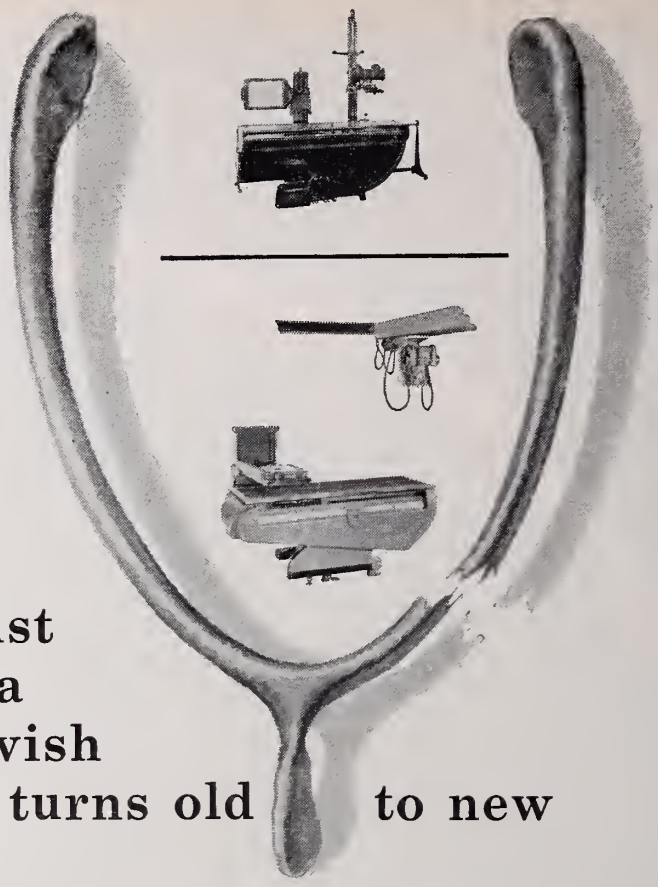
How Supplied: Bottles of 50, 100, 200 and 1000.

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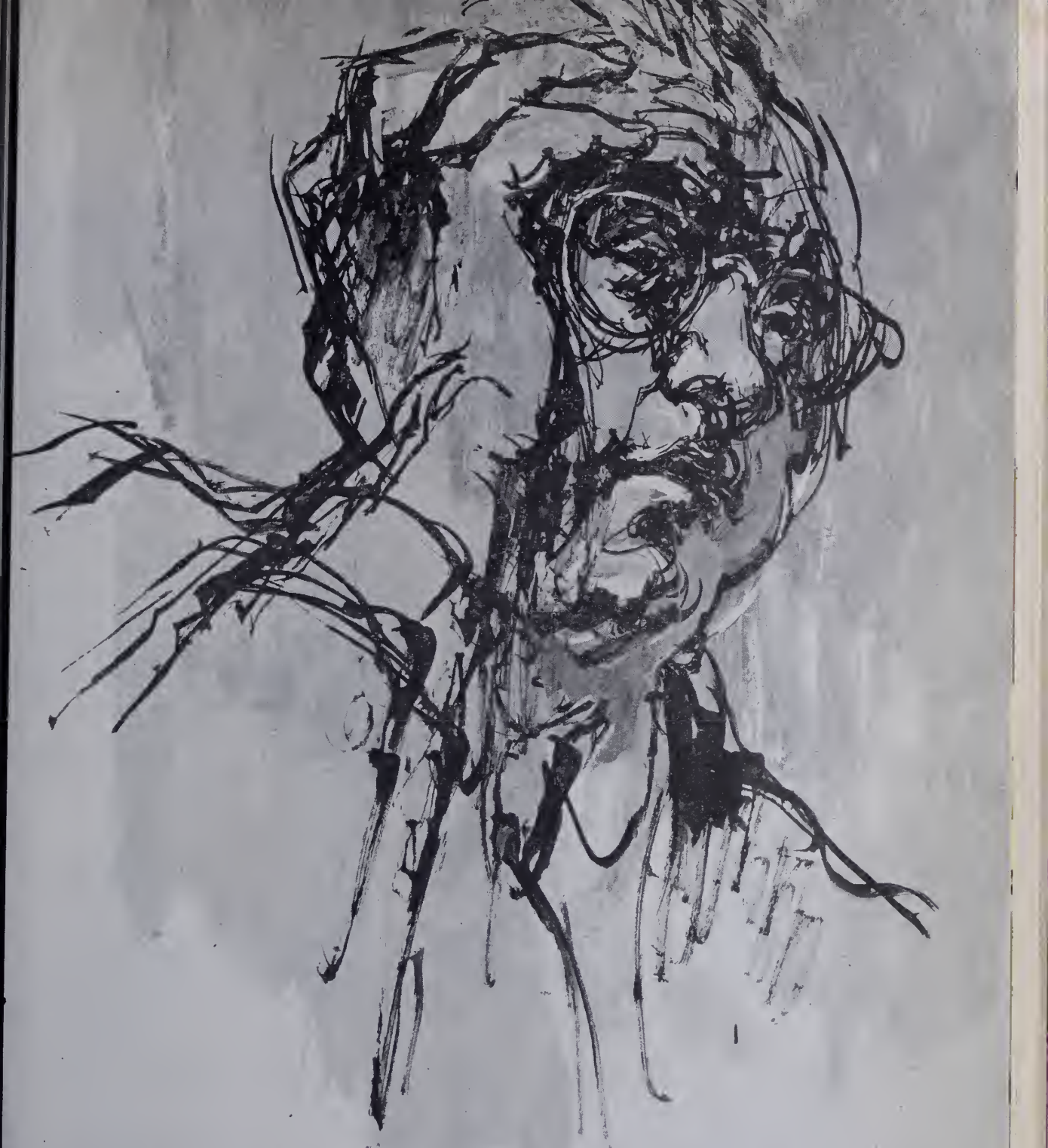
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Levin, Samuel J.: Management of the Acute Asthmatic Attack in Childhood. Ped. Clin. of N. A. *1*:975, (November) 1954.

"Its action is about as prompt as the solution, manifested in 1 to 5 minutes, and as prolonged as the oil suspension, lasting 8 to 12 hours."

Naterman, H. L.: Epinephrine Base Suspended in Water with Thioglycollate. J. Allergy *24*:60, (Jan.-Feb.) 1953.

"Greatest individual acceptance of the new injection has been by children. The dosage is small enough to be handled easily (0.30 to 0.40 cc. in adults; 0.15 to 0.20 cc. in children)."

Unger, A. H., and Unger, L.: Prolonged Epinephrine Action. A Report on Use of an Epinephrine Suspension. Ann. Allergy *10*:128, (Mar.-Apr.) 1952.

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Jenkins, C. M.: A Clinical Study of "Sus-Phrine", an Aqueous Epinephrine Suspension for Sustained Action. J. Nat. M. A. *45*:120. (Mar.) 1953.

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keeps the patient
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THE FIRST TRUE "TRANQUILAXANT"

Trancopal®

relieves painful muscle spasm and relaxes the patient



Impressive numbers of patients with low back pain and other musculospastic conditions treated with Trancopal have been freed of symptoms and enabled to return to their usual activities, according to newly published clinical reports. In a recent study by Lichtman,[1] Trancopal brought excellent to satisfactory muscle relaxation to 817 of 879 patients. The patients in this group suffered from skeletal muscle spasm associated with low back pain (361 cases), stiff neck (128 cases), bursitis (177 cases), and other skeletal muscle disorders (213 cases). Side effects were rare (2 per cent of patients), and it was not necessary to discontinue medication in any of the patients. Lichtman comments: "Chlormethazanone [Trancopal] not only relieved painful muscle spasm, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."[2]

When you prescribe Trancopal for musculoskeletal disorders, you can confidently expect that your patients will be relieved of the pain and stiffness. You can be sure of their speedy return to everyday work and recreation.

Mullin and Epifano call Trancopal "...a very effective skeletal muscle spasmolytic."[3] They found that Trancopal brought good to excellent relief to all of 39 patients with skeletal muscle spasm related to trauma, bursitis, rheumatoid arthritis, osteoarthritis, and intervertebral disc syndrome. (No side effects were noted except that one patient had slight dryness of the mouth.)

The pattern is similar in every new series reported: Ganz,[4] DeNyse,[5] Shanaphy[6] and Stough.

Trancopal is a true "tranquilaxant"

Trancopal "...combines the properties of tranquilization and skeletal muscle relaxation with no concomitant change in normal consciousness."[6]

Relieves dysmenorrhea



Trancopal not only is valuable in treating patients with low back pain and other musculoskeletal disorders, but is also very effective in bringing relief from menstrual cramps and discomfort. Shanaphy suggests that Trancopal may help the patient by its combination of muscle relaxant and tranquilizing actions, and he finds that "...the continued use of chlormezanone [Trancopal] as a therapeutic agent in dysmenorrhea is advisable."[6] Trancopal was effective in 82 per cent of his series of 50 patients. In another study, which dealt with 52 adolescent girls and 23 women, Stough[7] reported that Trancopal gave complete or moderate relief in 86.4 per cent.

Alleviates tension

And, of course, Trancopal is also very useful in the treatment of patients in anxiety and tension states. As Ganz says, "...a most valuable drug for relieving tension, apprehension and various psychogenic states...allows the patient to use his energies in a more productive manner in overcoming his basic problems."[4]

Trancopal

a true "tranquilaxant"

that relieves skeletal muscle spasm and relaxes psychogenic tension without troublesome side effects, and keeps the patient on the job.

Indicated for...

Musculoskeletal disorders		Psychogenic disorders
Low back pain (lumbago)	Fibrositis	Anxiety and tension states
Neck pain (torticollis)	Ankle sprain, tennis elbow	Dysmenorrhea
Bursitis	Myositis	Premenstrual tension
Rheumatoid arthritis	Postoperative muscle spasm	Asthma
Osteoarthritis		Angina pectoris
Disc syndrome		Alcoholism

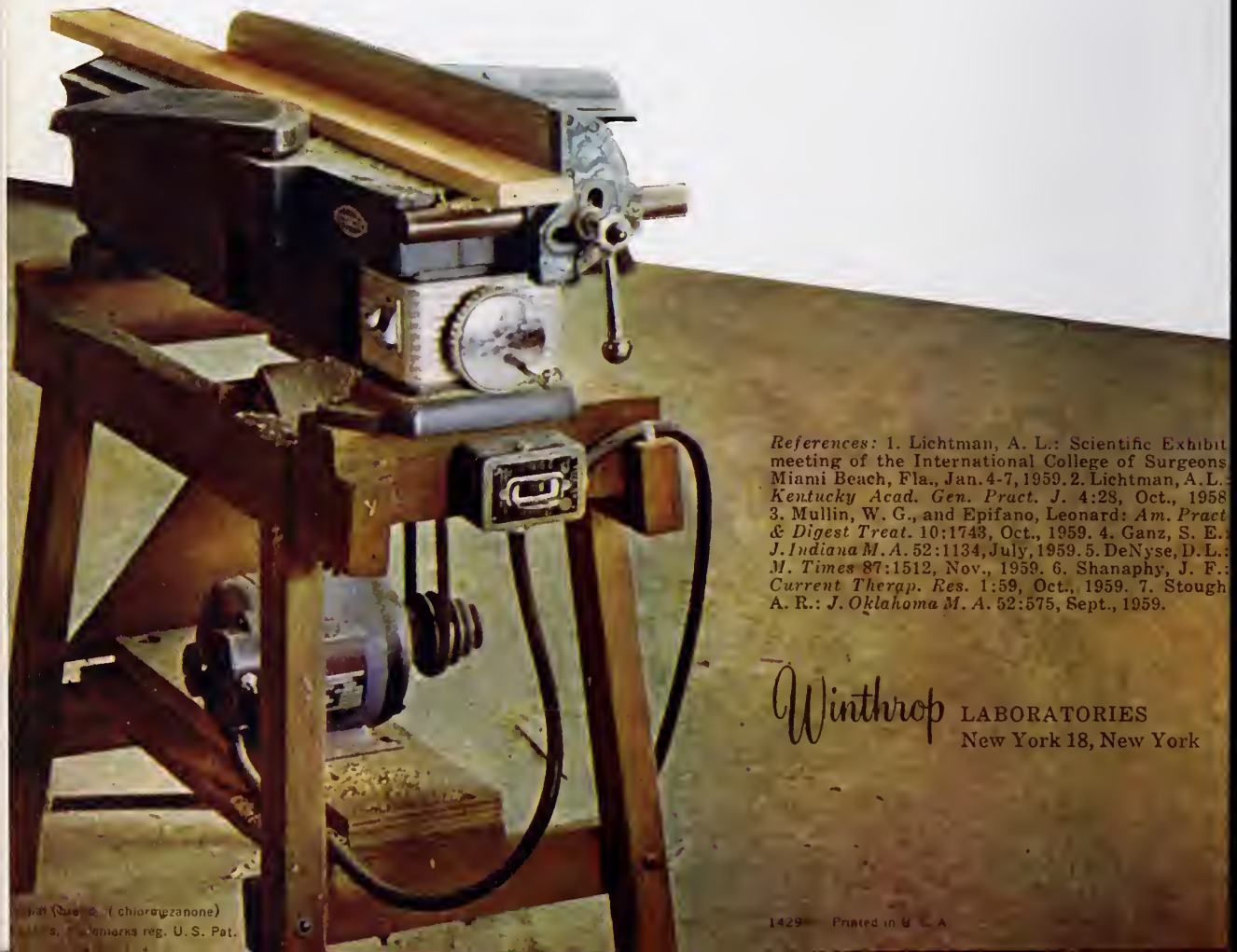
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References: 1. Lichtman, A. L.: Scientific Exhibit meeting of the International College of Surgeons Miami Beach, Fla., Jan. 4-7, 1959. 2. Lichtman, A.L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958 3. Mullin, W. G., and Epifano, Leonard: *Am. Pract & Digest Treat.* 10:1743, Oct., 1959. 4. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 5. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 6. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 7. Stough A. R.: *J. Oklahoma M. A.* 52:575, Sept., 1959.

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ALTAFUR was administered orally in varying dosage: the optimal dose is believed to be about 22 mg./Kg. daily.

Side effects were minimal in these patients, being limited to gastric intolerance in a few cases, usually controllable by giving the drug with or after meals. Laboratory studies performed before and after ALTAFUR treatment revealed no adverse influence on renal, hepatic or hematopoietic function, nor other signs of toxicity.

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Lysaught, J. N., and Cleaver, W.: Paper presented at the Symposium on Antibacterial Therapy, Michigan and Wayne County Academies of General Practice, Detroit, Sept. 12, 1959 (published Nov., 1959)

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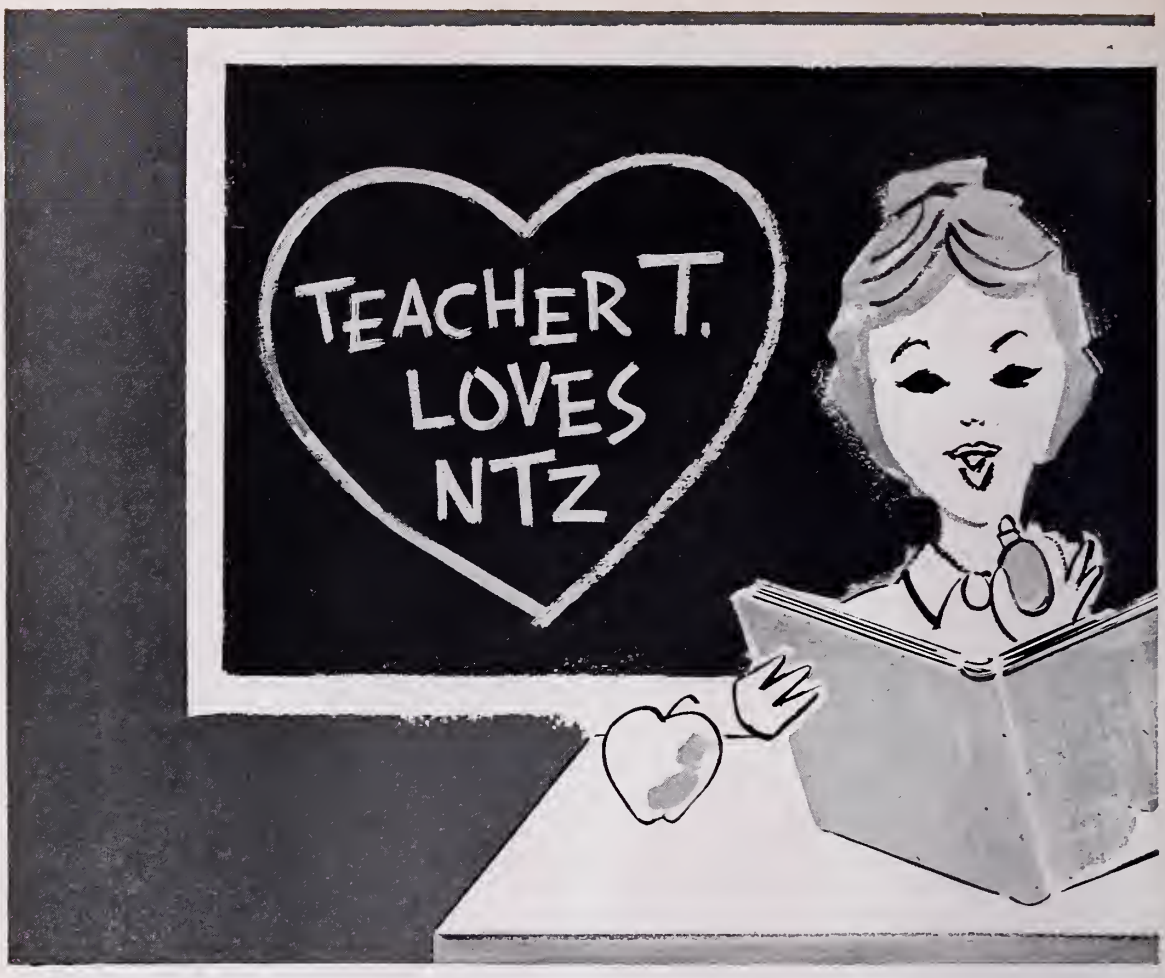


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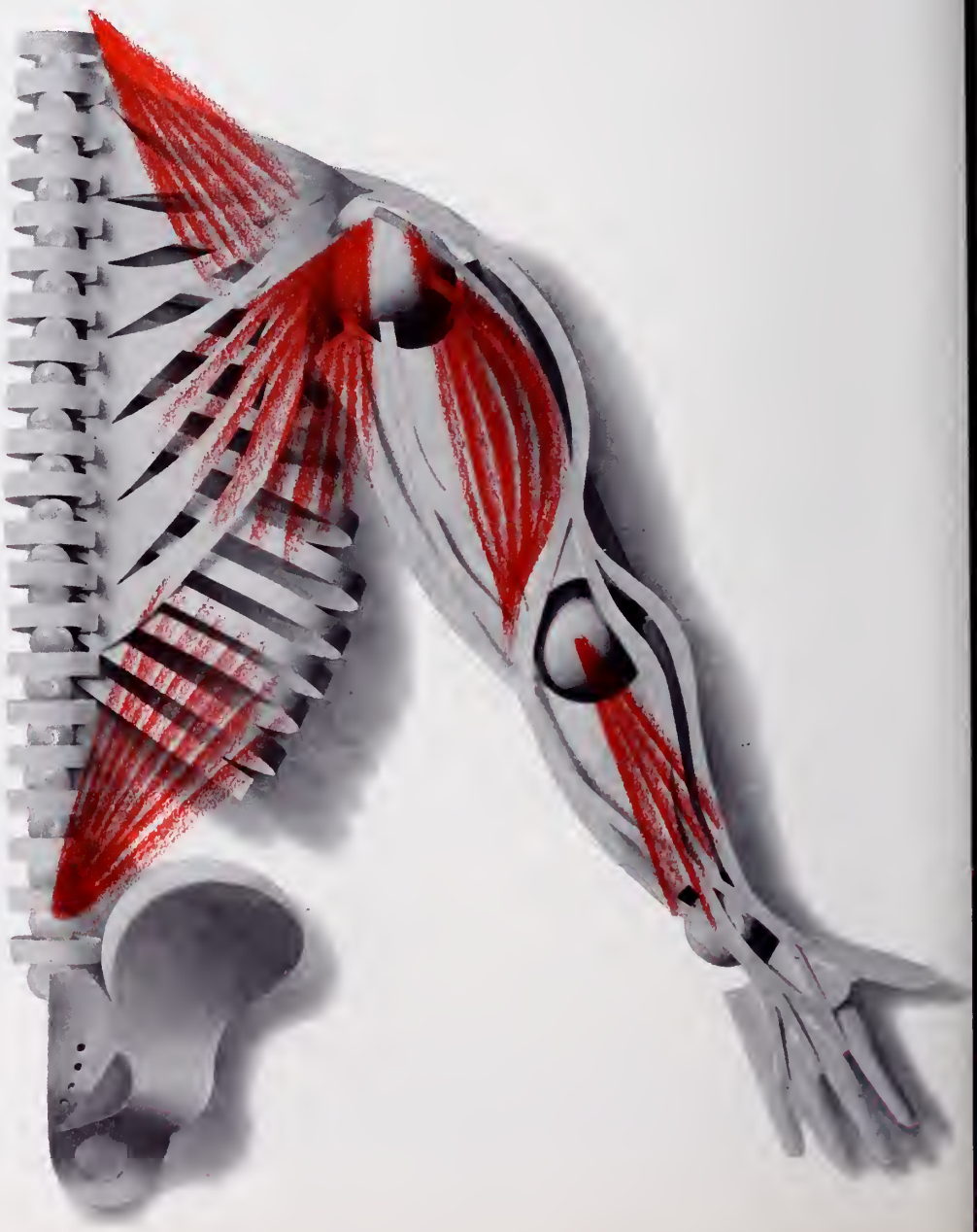
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Kuge, T.: Submitted for publication.

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Wein, A. B.: The Use of Carisoprodol in Orthopedic Surgery and Rehabilitation. Proceedings of the Symposium on The Pharmacology and Clinical Usefulness of Carisoprodol. Wayne State University Press, Detroit, 1959, p. 156.

In a double-blind study, SOMA was reported to be "clinically effective to a highly significant degree." (92 patients.)
Cooper, C. D., and Epstein, J. H.: The Clinical Evaluation of Carisoprodol by a double-blind technique. Ibid. p. 97.

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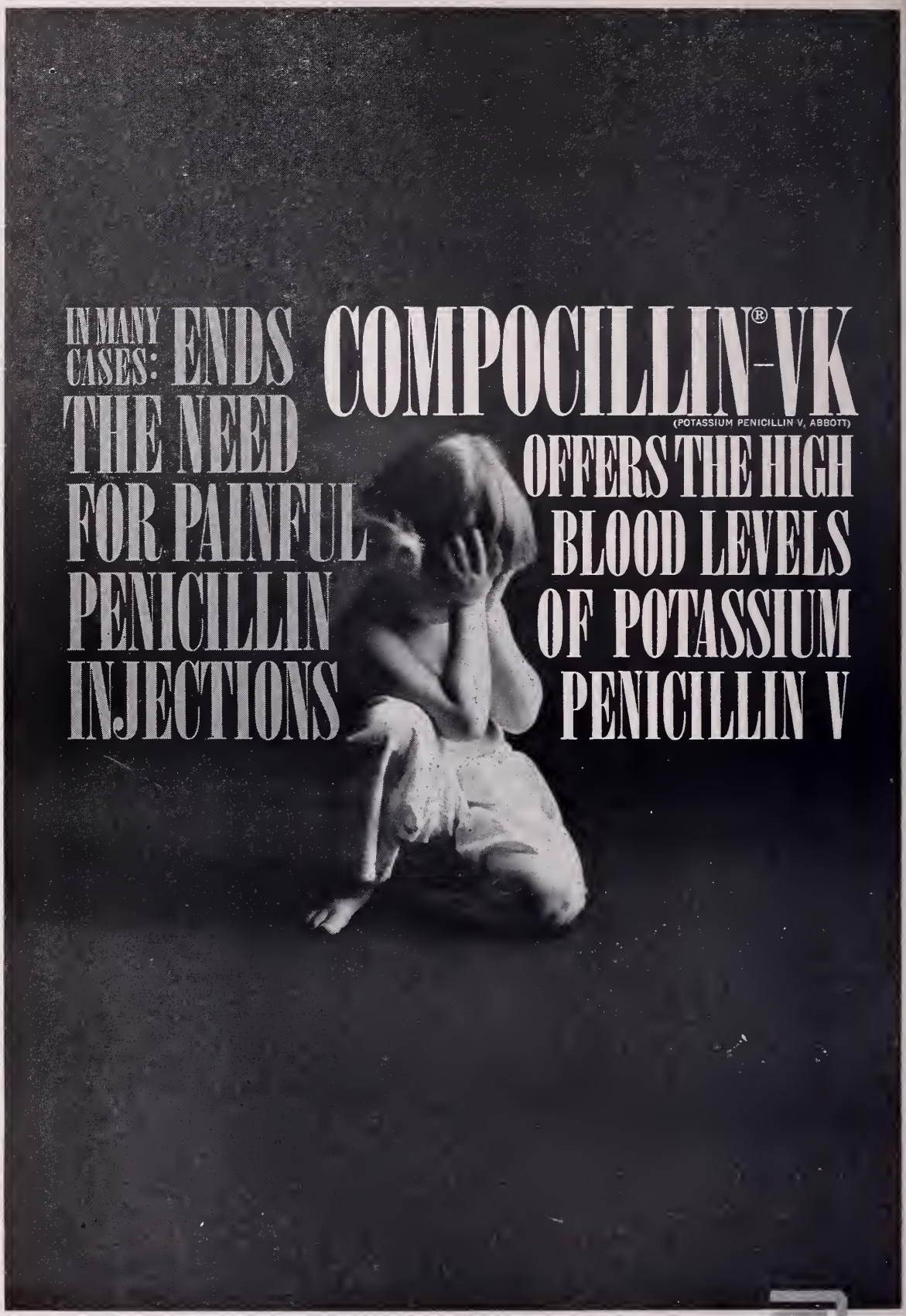
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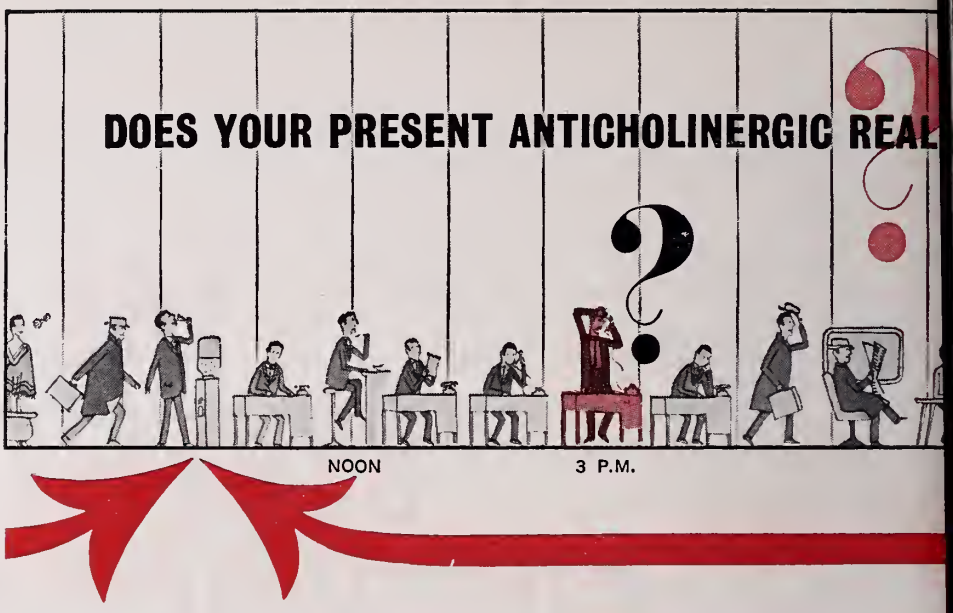
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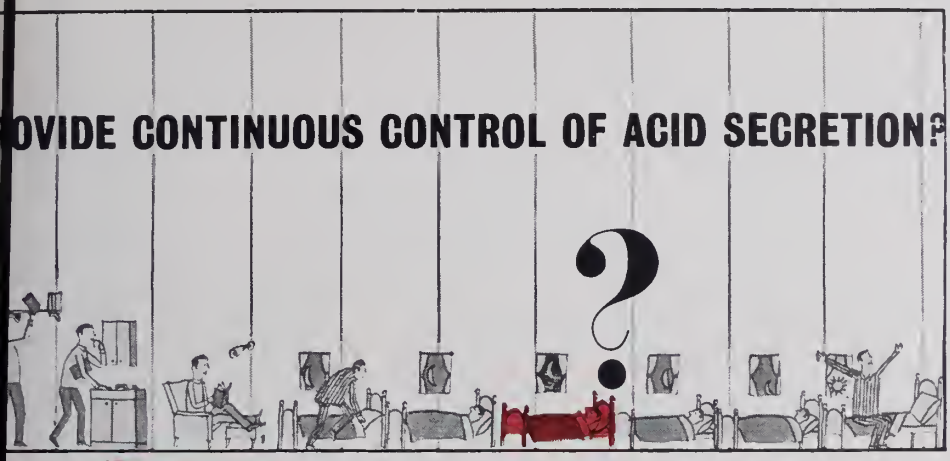
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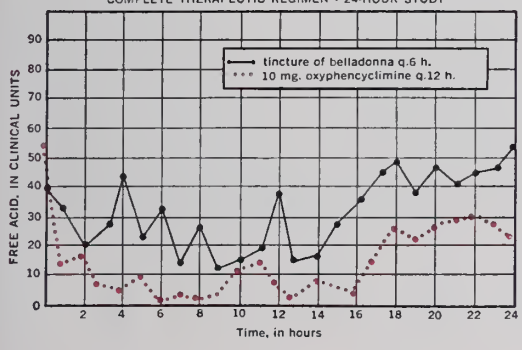
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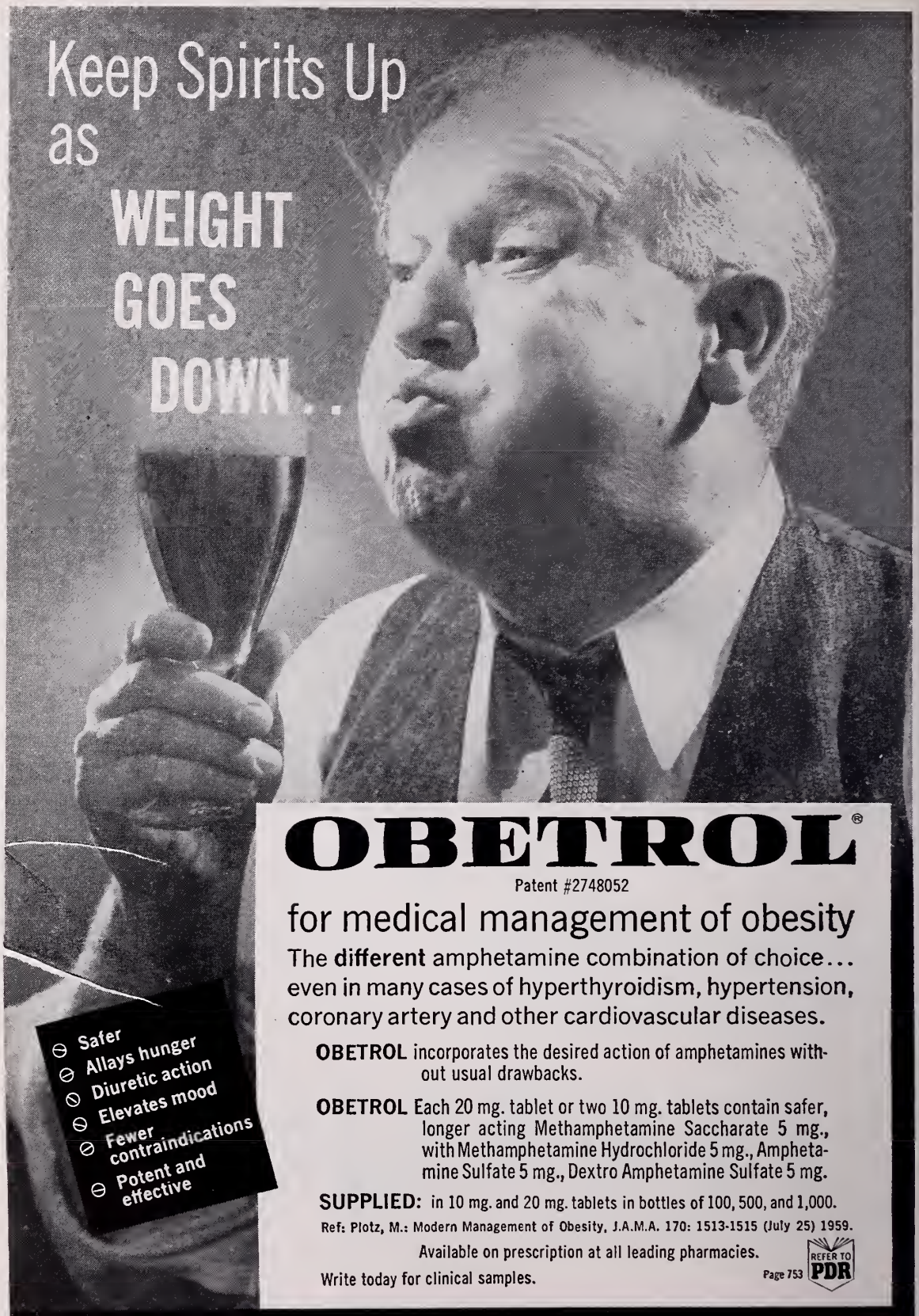
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Ref: Plotz, M.: Modern Management of Obesity, J.A.M.A. 170: 1513-1515 (July 25) 1959.

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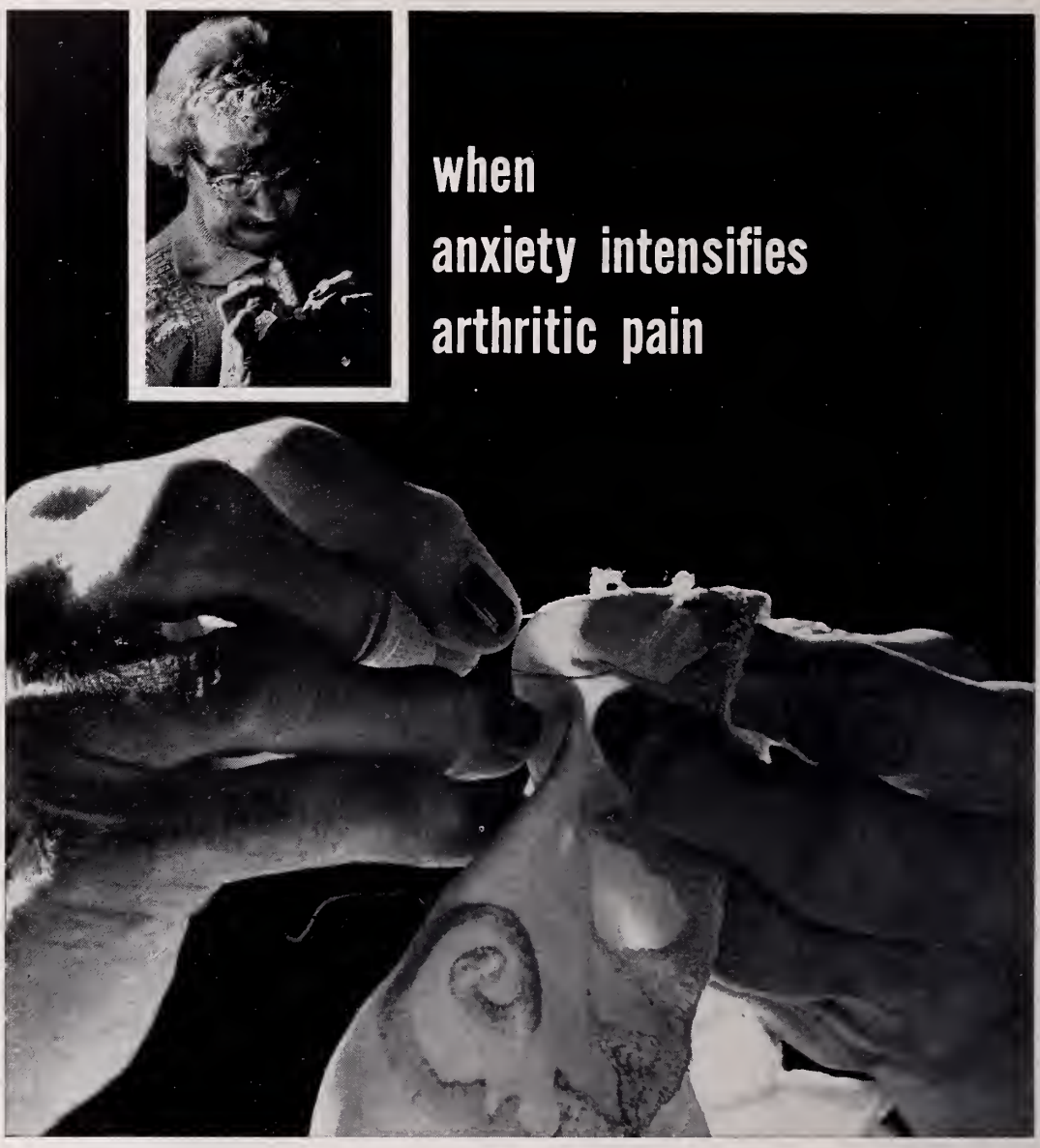
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Editorials • • ○

Which Path to Medical Security?

Although it is now twenty years since the medical profession gave birth to prepaid medical care, its ultimate patterns of operation and control are yet to be determined. The public will make the eventual decision. But we doctors can influence that decision. In the long run, the people—our patients—will support that system of medical care prepayment which offers them the best assurance of satisfactory professional service through physicians and institutions of their own choosing.

Today, several contrasting programs of medical prepayment are competing for popular and professional favor—each embodying a distinct concept of the relationship between patient and doctor.

One such program is a limited cash reimbursement policy. This offers the insured dollar indemnities against certain medical contingencies, irrespective of the physician's charges for the service required.

Another major program is medicine's Blue Shield Plan, which seeks—through professionally negotiated schedules of payment (and, in most areas, through the agreement of participating physicians) to assure the patient of fully paid professional services to a large proportion of patients.

A third system is the "closed panel" plan. This undertakes to provide a comprehensive service through a selected group of physicians remunerated by salary or per capita allowances, regardless of the volume of service required of them.

Which of these programs most faithfully reflects the traditional pattern of American medical practice? Which program is most clearly

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motivated—as medicine itself is motivated—to render service to the patient and to meet the needs of all segments of the community? Which program returns the fullest value to the patient and most fairly compensates the doctor? Which program best utilizes and protects the modes and ideals of practice that have earned American medicine the envy of other lands?

Which program will the American doctor favor—in the common interest of medicine and the people?

Is Student Quality Falling?

The January 14, 1960, issue of the New York *Times* carried a feature story captioned: "Student Quality Drops in Medicine." The opening sentence was: "A serious decline in the caliber of medical students is beginning to worry observers."

A decade ago, 18 per cent of the students entering medical school had an "A" average. Last year the figure was 10 per cent. The reasons given are interesting. One is that careers in physics (especially nuclear physics) are more glamorous. Another suggestion was that private practice had become so lucrative, that students who would ordinarily go into research and education, refused to enter medicine at all. The research-bound or teacher-trainee student, it is said, is likely to have a better academic average than the student who sets his sights at private practice. The logic of this one is a bit hard to follow. If the smart student decided to go into clinical practice instead of research, he would still be a medical student. If he was dedicated to research why would he switch to some other career when medicine needed him more than ever?

A third objection was that "some phases of the traditional medical education are considered obsolete." The theory was that this reduced the attractiveness of medical study. The writer did not point to the phases of the program which are considered obsolete, so it is pretty hard to answer this one—or even to understand it.

Some critics point out that the image of the doctor has changed over the years. It has become something of a cliché to say that a half-century ago, everybody loved "old doc" who was portrayed as an affectionate, dedicated and sometimes muddle-headed lover of the human race. Today, it is asserted, he has become a business-man, brisk, cold, and conspicuously prosperous. With this change of image, the more dedicated student finds medicine less attractive. The student who wants to make a lot of money, on the other hand, can do better in business—so medical schools lose at both ends.

In 1928, eleven per cent of all who won bachelor's degrees applied to medical school. In 1958 the figure was 4¼ per cent. A few decades ago, only 16 out of a hundred applicants were admitted. Today the figure is 53 out of every hundred applicants.

These figures need not have the gloomy implications of the *Times* article. Take the first item: 11 per cent of college graduates used to apply to medical school; now only 4¼ per cent apply. In the first place, this fails to consider the gross increase in the number of applicants: 12,000 in 1928; 16,000 today. In the second place, it fails to give weight to the development of new professional fields in pharmacology, space science, quality control, nuclear physics, color chemistry, and so on—fields which scarcely existed a half-century ago. Obviously as more professions open up, any one profession's share has to fall.

The second figure—53 per cent accepted now compared with 16 per cent a quarter-of-a-century ago—is not necessarily a bad one either. For one thing, medical schools overused the scare technic—they kept repeating that it was so tough to get in, that college men became convinced and many didn't even try. So that situation is better, not worse. We used to have a lot of trouble with the 84-out-of-every-hundred who were rejected by Ameri-

can medical schools. They entered paramedical specialties, or foreign schools, or even went into the cults. They became the great disenchanted on the margins of medicine. It is better now when more than half of the intelligent and well-prepared students can find medical school placements.

Dr. Robert Moore, of the Downstate Medical Center in Brooklyn, suggests that "four school years of time can be put into three." This would make a medical career more attractive to serious students. He also thinks that the conventional internship is obsolete because of the emphasis on clinical practice in the last year or two of medical school. These suggestions are certain to arouse some opposition but they represent at least a constructive approach to the problem.

Perhaps the most distressing aspect of this is the implication that tomorrow's doctors will be less qualified intellectually. This is a wild assumption to draw from the raw figures. The phrase "qualified intellectually" needs clarification. The major long range change—and by long range we mean over an entire century—has been the narrowing of scholarship in the physician. Once the M.D. was a real scholar who could read Greek, talk fluently of the classics, and had a solid core of learning in many areas. While his learning today may go deeper, it is also narrower. If you want a broad grasp on the humanities you seldom look to the medical practitioner. The physician is no longer the archetype of the intellectual. Being less intellectual, however, does not mean being less intelligent, though it does mean being intelligent in a different way.

Things are not the way they used to be and they probably never were. Every generation has wailed at the decline of its brethren and children. We suspect we will survive the present requiem, too.

Smugness, Sepsis and Syphilis

It seems to be in the cards—or maybe in the stars—that as soon as we make a solid advance in medical science, and we sit down to pat ourselves on the back, some little gremlin comes along and tells us that there is no cause for congratulations. Not so long ago we were anticipating the elimination of syphilis. We became less vigilant. Now for the first time in many decades, the syphilis infection rate is beginning to rise.

The triumph of the antibiotics is still a proper subject for praise. However, germs are now being born which seem to have a built-in resistance. Our search for newer antibiotics reminds one of the eternal quest for stronger and stronger armor plate as the munition makers develop more and more powerful bullets.

The most recent example of the effect of our smugness is the development of anxiety about hospital sepsis. For half a century we have watched with great self-satisfaction the lessening toll from puerperal sepsis, wound infections and infectious gangrene. While we thus became increasingly complacent about hospital infection, we also developed some degree of boldness in the scope, speed, casualness and number of our surgical operations. To accommodate the increasing tempo of the operating room, we streamlined numerous hospital practices. Instead of depending on technical niceties, we began to depend on anti-infective preparations. We expected that the fight against sepsis would be carried on by other people and would be done in a push-button fashion.

Now we realize that no infection can be considered "minor." Now we are faced with problems of hospital epidemiology and infectious control that must make Semmelweiss and Lister chuckle.

The moral is plain and written in letters so large that he who runs may read. The battle against disease and death is never won and eternal vigilance is the price of health. We may feel proud of our achievements but there is a difference between pride and complacency. There can be no holiday in the endless struggle against infection, disorder and death itself.

JEROME ABRAMS, M.D.

Plainfield

Sickling and Pregnancy

Obstetrical patients of Negro or Puerto Rican descent are entitled to screening for hemoglobinopathies. Why and how to do it are detailed in this practical paper.

THE sickle cell trait or sicklemia occurs in about 8 per cent of the American Negro population,[1,2] and in a very much smaller proportion of people of Mediterranean ancestry, including natives of Puerto Rico. Under conditions of reduced oxygen tension erythrocytes from the peripheral blood of these people undergo "sickling" or become sickle-shaped. Nearly 98 per cent of those people whose erythrocytes undergo "sickling" possess the sickle trait; over two per cent[3] have sickle cell anemia, or more specifically, one of the sickle cell diseases.

Until recently the differential diagnosis between sicklemia and sickle cell anemia depended upon evaluations of history, physical signs, sickling preparations, complete blood counts, reticulocyte counts, and determination of serum bilirubin.[4] These factors varied with the method of sickling preparation, nutritional status of the patient, and severity of the disease. Consequently, there were severely anemic, malnourished patients with sicklemia who were diagnosed as having sickle cell anemia.[5] Occasionally, there were patients wth mild sickle cell anemia, moderate nutritional anemia, without icterus or a history of hemolytic crisis; by means of these diagnostic criteria, they were frequently diagnosed as sicklemia.

During the past ten years a new diagnostic method has made it possible to differentiate accurately sicklemia from the sickle cell diseases as well as to diagnose specifically the different sickle cell diseases. By this method,[6] hemoglobin is analyzed with paper electrophoresis[7] so that the exact type or types of hemoglobin possessed by the individual patient may be demonstrated with certainty. Many different hemoglobins have been identified by electrophoresis since 1949, and have been designated by letters of the alphabet; *e.g.*, A (adult normal), F (fetal), S (sickling), C, D, E, and so forth. Sickle cell anemia is now represented by at least three hemoglobinopathies (sickle cell disease *per se*, sickle cell-C disease, sickle cell-D disease). The Table lists five hemoglobin combinations.

HEMOGLOBIN COMBINATIONS

Phenotype	Genoypte	Hemoglobin
Normal	A A	A
Sickle cell trait	S A	A S
C trait	C A	A C
Sickle cell disease	S S	S F
Sickle cell-C disease	S C	S C

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2. Curtis, E. M.: Pregnancy in Sickle Cell Anemia. Am. J. Obst. & Gynec., 77:1312 (1959).
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Hemoglobin paper electrophoresis clarifies the mechanism of the inheritance of the sickle cell diseases. It becomes readily apparent by referring to the Table, how an offspring may receive an S S genotype from two parents, each possessing the sickle cell trait (S A genotype). The sickle cell trait[8] does not represent a complication of pregnancy[9] nor any other pathologic condition; the only known significance is that the offspring may inherit sickling. Sickle cell diseases represent a true complication of pregnancy,[2,5,10,11,12] contributing to increases in mortality and morbidity of mother and fetus. Recent reports[2,5,12] have tended to confirm Smith and Conley's impression[13] that sickle cell-C disease is more serious than sickle cell disease when complicated by pregnancy.

Therefore, it is important that there be increasing awareness of the methods of diagnosis and management of the sickle cell diseases. Hemoglobin paper electrophoresis is being used with greater frequency and accuracy in more and more hospitals. But until it is everywhere available, it would be worthwhile to consider a practical program that could be readily introduced in almost any hospital in the United States.

DIAGNOSIS

All obstetric patients of Negro or Puerto Rican descent should be screened for hemoglobinopathies by a peripheral blood smear and by means of a sickling preparation[14] according to Daland's method.[5]

If the sickling preparation is positive and/or the peripheral blood smear reveals an inordinate number of target cells (suggestive of a non-specific hemoglobinopathy), reticulocyte count, serum bilirubin, and complete blood count should be done. Repeated attempts should be made to discern hepatic and/or splenic enlargement. The patient should be reinterrogated specifically concerning a familial history suggestive of hemolytic anemia, past history of leg ulcers, diagnoses of rheumatic heart disease, and episodes of hemolytic crises. If the results of these efforts suggest one of the sickle cell diseases the patient should be seen at least twice as often as the regular antepartum patient. She should be encouraged to call or visit the obstetrician at the slightest indication of severe respiratory tract infection, urinary tract infection, thrombophlebitis, and the like. Active treatment of these minor complications may thus be readily instituted; if there is no significant, prompt improvement, hospitalization may be advised. Hospitalization will insure more prompt and specific diagnosis of infection, accurate dosage and administration of the indicated antibiotic, bed rest, well-balanced diet, adequate hydration, and observation for the first sign of impending hemolytic crisis.

HEMOLYTIC CRISES DURING PREGNANCY

Bed rest, adequate hydration, and antibiotic therapy of infection are the basic, cardinal features of therapy of hemolytic crises during pregnancy or at any other time. Routine prophylactic administration of antibiotics does not serve a useful purpose. Oxygen is administered only in the presence of dyspnea and/or fetal distress. Transfusions with packed red blood cells are administered slowly when the hemoglobin level falls below 7 Grams per cent. The patient with sickle cell disease, having become accommodated to lower hemoglobin levels should *not* be transfused with pints of whole blood to attain the so-called normal or safe hemoglobin level of the obstetric patient without hemoglobinopathy.[5] Operative delivery

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is *not* indicated merely because the patient has or has had a hemolytic crisis.

COMMENT

ACCURATE hematologic diagnosis will enable the clinician to direct his attention to patients with the sickle cell diseases and other hemoglobinopathies and avoid unnecessary prophylactic measures with patients possessing the sickle cell trait. An increasing awareness of the necessary diagnostic and prophylactic measures that can be readily instituted in any hospital should ameliorate the effects of hemolytic crises and possibly decrease their incidence. Time-honored, conservative obstetrical procedures with hematologic consultation will decrease the high incidence of maternal and fetal mortality and morbidity and will not complicate further a pregnancy already complicated by sickle cell disease.

SUMMARY

1. Hemoglobin paper electrophoresis is recommended as an accurate means of differentiating sicklemia from the sickle cell diseases and of diagnosing specifically the different sickle cell diseases.

2. Antepartum patients may be screened by Daland's sickling preparation and peripheral blood smears, followed by paper electrophoresis wherever practical.

3. Where paper electrophoresis is impractical, accurate history and physical examination plus blood counts, reticulocyte counts, and bilirubin determinations will alert the obstetrician to the possibilities of the sickle cell diseases and crises.

4. Frequent antepartum examinations and conservative obstetric and hematologic principles of management of the sickle cell diseases in pregnancy and labor were emphasized.

323 West Ninth Street

School Athletic Activities

You are invited to attend a unique symposium on Saturday morning, April 2 at the Seton Hall College, Ward Place at South Orange Avenue in South Orange. The topic is: Student Athletic Activities and the Prevention of Injuries. Moderator is Dr. Robert E. Jennings, Chairman, Committee on Child Health, The Medical Society of New Jersey. The colloquium starts promptly at 9:45 a.m. and will be over by 1:15 p.m. The program:

1. Physical Fitness of the School Child—Stuart S. Stevenson, M.D., Chairman, Department of Pediatrics, Seton Hall College of Medicine
2. A Program for Athletic Activity in New Jersey—Everett L. Hebel, Ed.D., Director, Health-Safety-and Physical Education, State Department of Education, Trenton
3. The Athletic Program in an Urban School System—Richard R. Robinson, Ed.D., Superintendent of Public Schools, Trenton
4. The Athletic Program in a Private School—Charles B. Atwater, Head of Middle School, The Pingry School, Elizabeth
5. The Parents' Viewpoint of Athletics—Mrs. Kenneth W. Lathrope, president, New Jersey Congress of Parents and Teachers, Neshanic Station
6. Types of Athletic Injuries in Various Sports—Robert G. Greene, M.D., Attending in Orthopedic Surgery, Mountainside Hospital, Montclair
7. Prevention of Dental Injuries—Benjamin A. Brown, D.D.S., president, New Jersey Dental Society, Ventnor
8. The Role of the Coach and of the Referee in Injury Prevention—E. R. Cooper, Director, Health-Safety-Physical Education-and Athletics, Public Schools, Linden
9. The Role of the Team Physician in Prevention and Treatment of Athletic Injuries—William J. Farley, M.D., Associate Pediatrician, St. Michael's Hospital, Newark; and Team Physician, Nutley High School, Nutley.

William Furst, M.D.

East Orange

Psychopharmacologic or Electrical Therapy of Severe Endogenous Depression?

A Clinical Evaluation

For two decades, electronic therapies have been the sovereign treatment for depressions. If Dr. Furst is right, this era may be drawing to a close with the development of safe and potent antidepressant drugs.

Severe endogenous depression is a medical emergency. In this common mental disease, psychopathologic explanations have dominated etiologic concepts until recent times. Major advances in contemporary brain chemistry and physiology may require radical alteration in our understanding of this intriguing illness which affects such large numbers of people and which produces the highest suicidal rate of all mental disorders.

The target symptoms of endogenous depression, which this author considers a biologic, constitutional, somatic disease are:

(1) *Anergia*—a loss of drive, energy, interest in or capacity for work, of rather sudden onset.
(2) *Anorexia*—usually severe with rapid weight loss.
(3) *Insomnia*—typified by early morning awakening, inability to return to sleep, and refractoriness to high doses of sedative drugs.
(4) *Anhedonia*—the inability to enjoy *any* pleasure.
(5) *Depression*—usually severe in the morning, lifting in the evening. Suicidal ideation usual.
(6) *Somatic complaints* frequently mistaken for intercerebral, gastrointestinal or cardiopulmonary, vascular or menopausal disease unrelieved by appropriate medication. Disturbances of water metabolism are frequent, revealed as dryness of the mouth and constipation.

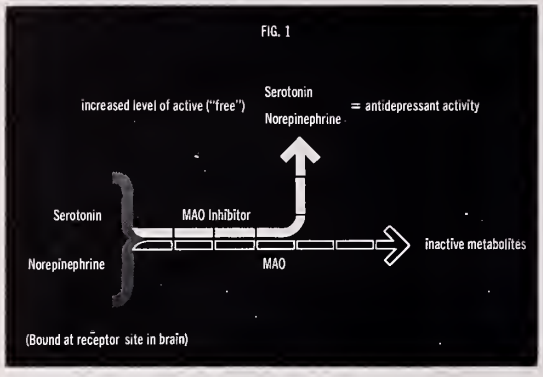
Prior to the introduction of convulsive type treatments in 1936, little effective therapy was available for this disease. Cerletti's [1] inauguration of electrotherapy in 1938 made a readily available means of helping large numbers of depressed patients. In 1940 I reported on 250 cases treated by electroconvulsive therapy with remissions produced in a high proportion of cases.[2]

The rediscovery in recent years that reserpine had profound psychopharmacologic effects in man set the stage for concentrated study of brain chemistry. Reserpine not only reduced blood pressure but frequently produced profound depression.

Fox [3] in 1952 synthesized iproniazid. This not only reversed the reserpine-induced slowing of activity in experimental animals but also neutralized mood depression in man. The evidence suggests that iproniazid along with numerous other drugs has an inhibiting action on the body enzyme monoamine oxidase [4]

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3. Fox, H.: Journal of Organic Chemistry, 17:555 (May 1952).
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which results in increased levels of serotonin [5] and norepinephrine [6] in the brain of experimental animals, and presumably in man. A schematic interpretation of these events is presented in Figure 1.



Brodie, *et al.*[7] consider serotonin a neurohumor which chemically transmits impulses to the parasympathetic and norepinephrine to the sympathetic nervous systems. Woolley and Shaw [8] postulated that increased serotonin caused contractions of brain oligodendroglia to facilitate circulation of extravascular fluids, thus modifying brain functions. Clinical investigators, the first of which was Kline, *et al.*,[9] drew attention to the beneficial effects of iproniazid in reversing endogenous depression.

Due to the toxic effects of iproniazid (mainly in producing hypotension, hepatitis, edema and weight gain) analogues have been made available in increasing numbers for clinical trial. These have varying degress of monoamine oxidase inhibiting strength, beneficial effects, and undesirable side effects.

Phenelzine* (Nardil®) has in my experience been as chemically effective as iproniazid and produces less toxic side effects.[10] Following treatment with phenelzine* satisfactory remissions were obtained in 70 per cent of 36 severely depressed private patients. Average daily dose ranged from 60 to 90 milligrams daily. Since this initial report and with further experience involving a larger number of cases, the figure has come closer to 80 per cent. In my experience, an 80 to 90 per cent remission rate may occur in severe depression with the use of electrotherapy; but the social stigmata, memory impairment, induced anxiety and occasional adverse physical reactions make an alternative treatment more desirable.

The pros and cons of psychopharmacologic agents *versus* electrotherapy are briefly summarized in the chart.

NARDIL®

Pro	Con
1) More readily accepted by average patients.	1) May cause mild G.I. distress.
2) Less costly.	2) Possibility of hypotension on prolonged usage requires constant follow-up.
3) Permits continuation of work.	3) May precipitate hypomania.
4) No induced amnesia.	4) Insomnia on large doses.
5) No physical complications of serious nature.	5) Slower remission undesirable where suicidal ideation present.
6) Simplicity of treatment.	6) Easy administration may result in over- or under-dosage.
7) Relieves cardiac and arthritic pain.	
8) Very few contraindications.	

ELECTROTHERAPY

1) Higher remission rate.	1) Requires special equipment, training and assistants.
2) More rapid remission is usual.	2) Produces memory impairment with occasional permanent retrograde amnesia.
3) Desirable where suicidal drive is strong.	3) More expensive.
4) Effective in improving sleep where sedatives are inadequate.	4) May result in fractures or other physical injury.

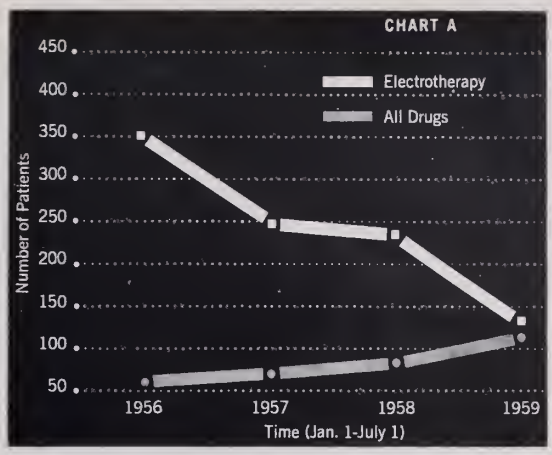
During the past four years there has been a progressive increase in the use of antidepressant drugs by this author, and a concurrent decrease in the use of electrotherapeutic methods. This is not to gainsay the fact that

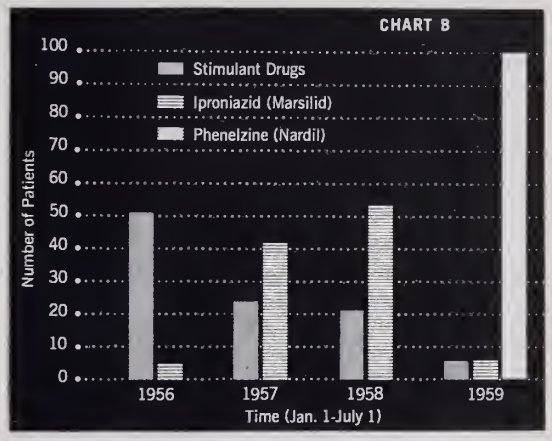
*Phenelzine, tradenamed as Nardil® was supplied for this study by the manufacturer, Warner-Chilcott Laboratories of Morris Plains, N. J.

electrotherapy still has a very useful place in treatment. Nevertheless, by referring to Chart A it is apparent that at the clinical practice level, the antidepressant drugs may find use in a large proportion of depressions formerly treated with electrotherapy.

I have extended my initial experience with the use of phenelzine,* and have now accumulated 150 cases of endogenous depression treated by this drug. The reduced use of various stimulant drugs (Dexedrine®, Dexamyl®, Ritalin®, Meratran®, Suavitil®, Deaner®, and Marsilid®) compared with the increased use of Nardil® in my private practice is shown in Chart B.

Disappointment is bound to result from the use of a monoamine oxidase inhibitor if it is prematurely discontinued. This is borne out by the fact that during a recent trial with a small number of patients, King [11] discontinued phenelzine* after four weeks of use. He had drawn the conclusion that it was of no value and consequently instituted electrotherapy. In my own experience, in a high proportion of cases, good results with phenelzine* *do not occur until after 4 to 6 weeks.* It may take this long on the standard dose for the monoamine oxidase to be sufficiently neutralized to permit an accumulation of brain neurohumors for effective action. The rarity of side effects with phenelzine[9]* makes this drug particularly desirable for ambulatory use.





and pharmacologic therapy are charted. The increasing use of monoamine oxidase inhibiting drugs to replace electronic therapies is diagrammed. Phenelzine* has distinct advantages over iproniazid primarily because of the relative absence of side effects of the former.

SUMMARY

SPECIFIC pharmacologic treatment for severe endogenous depression based on more solid scientific grounds than empirical electrical therapy seems imminent. The characteristic symptomatic clinical picture is presented.

The discoveries leading up to the use of monoamine oxidase inhibition are cited. Phenelzine,* a less toxic drug than iproniazid, has found increasing use in ambulatory treatment of severe endogenous depression. The advantages and disadvantages of electrical

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CONCLUSIONS

(1) In severe endogenous depression, drug therapy approaches the effectiveness of electrotherapy. In many cases it may be the treatment of choice.

(2) Based on the results of a clinical trial with 150 ambulatory private patients, phenelzine,* a new monoamine oxidase inhibitor, has been highly effective in relieving severe depressive states. Due to the rarity of side effects, phenelzine* has a distinct advantage over iproniazid as an antidepressant drug.

49 South Munn Avenue

Is There An Alcoholic Executive in Your Family?

There is growing evidence, says *Fortune* magazine, that alcoholism among business executives is a serious problem. The age at which a man is most likely to be made an executive (35 to 45) is the age at which alcoholism most often reaches the serious stage. And as an executive takes on more responsibility he is subject to greater stress. The bottle may be the easiest way to relieve the tension.

Because the stigma attached to alcoholism keeps the alcoholic executive away from his company doctor, says *Fortune*, there are few statistics to go by. Two experts, Mrs. Marty Mann, executive director of the National Council on Alcoholism, and Dr. Ruth Fox, the Council's medical director, think that alcoholism among executives is widespread.

"The higher the economic level, the higher the percentage of drinkers," says Dr. Fox.

The alcoholic executive may be able to muddle along at half speed for quite a while. Although slowed by a hangover in the morn- and four martinis at lunch, he manages to come to the office and get some work done.

Even the out-and-out alcoholic executive may be able to stay on his job for a long time. His mobility and privacy make it easy for him to cover up his drinking. He is often protected by a devoted secretary, sometimes even by higher executives who believe he will straighten out on his own if given another chance.

The incidence of alcoholism is high in groups with a tradition of hard drinking, such as advertising, journalism, railroading and aircraft manufacturing.

With its article on alcoholism, *Fortune* includes a questionnaire from the book, "The Drinking Problem and Its Control," by Dr. C. Anthony D'Alonzo, assistant medical director of du Pont.

No questionnaire, warns Dr. Alonzo, can determine whether or not anyone is an alcoholic, but even one "Yes" may indicate trouble. If three or more questions are answered "Yes," or a general drift to the affirmative is evident, then there is definite reason to worry.

The questionnaire:

1. Do you lose time from work because of drinking?
2. Is drinking making your home life unhappy?
3. Do you drink because you are shy with other people?
4. Is drinking affecting your reputation?
5. Have you ever felt remorse after drinking?
6. Have you ever gotten into financial difficulties as a result of drinking?
7. Do you turn to lower companions and to an inferior environment when drinking?
8. Does your drinking make you careless of your family's welfare?
9. Has your ambition decreased since drinking?
10. Do you crave a drink at a definite time daily?
11. Do you want a drink the next morning?
12. Does drinking cause you to have difficulty in sleeping?
13. Has your efficiency decreased since drinking?
14. Is drinking jeopardizing your job or business?
15. Do you drink to escape from worries or trouble?
16. Do you frequently drink alone?
17. Have you ever had a complete loss of memory as a result of drinking?
18. Has your physician ever treated you for drinking?
19. Do you drink to build up your self-confidence?
20. Have you ever been to a hospital or institution on account of drinking?

Calvin E. Oyer, M.D.

Kearny

Tolbutamide in Treatment of Diabetes Mellitus*

Results in Patients Followed Up to 17 Months

This unpretentious but careful study of an oral antidiabetic won the Johnson award. Dr. Oyer's findings suggest that even in a highly selected group, the long-range success ratio will scarcely exceed 50 per cent.

Tolbutamide, 1-butyl-3-tolysulfonylurea, is one of the sulfonylurea derivatives receiving extensive clinical trial in diabetes mellitus. Experiences with tolbutamide appeared in the German literature [1] in 1956. The drug has since been undergoing extensive clinical investigation in this country.

Pharmacodynamics

Though the precise pharmacodynamic mechanism remains unknown, several possible paths of action seems satisfactorily excluded. Fajans, *et al.*,[2] found no evidence of decreased function of the pituitary-adrenal system and no evidence of blocking of the peripheral effects of adrenocortical steroids following administration of the compounds. The same investigators found no potentiation of exogenous insulin activity. Renold, *et al.*,[9] saw no elevation of plasma insulin-like activity after administration of tolbutamide to healthy young males. Their studies also suggested that "increased peripheral glucose utilization is not a major component of tolbutamide action."

Studies in dogs,[4] involving infusion of tolbutamide into the pancreatic artery (as contrasted with infusion into the portal vein) suggest a pancreatic mechanism. These agents do not work in the absence of the pancreas in humans; they work poorly in juvenile diabetics. They do not produce hypoglycemia in alloxanized animals (in whom the beta cells have presumably been destroyed). These three facts have been cited,[11] as suggesting that insulin or insulin precursors must be present in the pancreas before the sulfonylurea derivatives will act. Some [10] have indicated, with reservation, their belief that these compounds produce hypoglycemia by stimulating the beta cells to secrete insulin.[4] On the other hand, the sulfonylureas do not alter glucose tolerance tests in normal persons. This does not support the stimulation-of-the-beta-cells theory of mode of action. Further evidence against this theory was provided by the same authors,[7] who showed that changes in blood pyruvate after tolbutamide administration followed a completely different pattern from the changes seen after insulin administration. The response of adrenalectomized animals,[3] to the sulfonylureas is also at variance with their response to insulin [11] offering further evidence failing to support the theory of stimulation of insulin secretion.[13]

The possible mode of action of tolbutamide

*From the Metabolic and Endocrine Clinic, Department of Internal Medicine, Saint Michael's Hospital, Newark, N. J. This paper was the winner of the Johnson Award.

that has received the least contradiction is that of influencing hepatic glucose synthesis. Renold, *et al.*,[9] have shown that the hyperglycemia following intravenous galactose and fructose is decreased by the previous administration of tolbutamide even though glucose tolerance is unchanged. This observation in addition to findings [12] of others,[6] has been interpreted as suggesting that tolbutamide acts *via* an effect on hepatic glucose synthesis or release.

Regardless of the mechanism, *a definite hypoglycemic action of tolbutamide has been demonstrated in normal and diabetic man.*

Mirsky,[14] reports that normal man shows a two-phase response. First there is a maximum decrease in blood sugar occurring within one hour. This is followed by a period of restitution. Diabetics show a variable response from a slight rise in blood sugar to a pronounced decrease. The decrease occurs maximally in about 5 hours instead of within 1 hour as in normals.

PRESENT STUDY

THE present study is a report on tolbutamide in 22 diabetic patients treated on an ambulatory basis for 1 to 17 months (average 10 months). No patient selected for treatment had received more than 30 units of insulin daily. None had a history of diabetic acidosis or coma. Insulin was discontinued at least one day prior to starting Orinase®. Most patients were given 3 Grams on the first day, 2 Grams on the second day and then maintained on 1 Gram daily, given in equally divided doses twice a day. In 19 patients blood specimens were taken for sugar determinations (Folin-Wu) at 8 a.m., 10 a.m. and 12 noon on the day on which 3 Grams of tolbutamide were given at 8 a.m., as described by Camerini-Davalos, Marble and Root.[15]

RESULTS

OF THE 22 patients, 12 showed control which could be termed successful. Ten showed inadequate control which had to be classified as failure. The treatment was considered successful if the fasting blood sugar was consistently below 180 and there was only rare glycosuria or none. The therapy was considered a failure when the fasting blood sugar was frequently over 180 and/or there was frequent 3 plus or 4 plus glycosuria. Patients were easily classified as successes or failures, since no one showed continuing borderline response. In the event of failure the patients were given insulin or another oral hypoglycemic agent. The long-range overall success ratio was 12 out of 22 or 54 per cent.

SECONDARY FAILURES

FOUR of the patients who are tallied as failures showed successful control for 10, 11, 12 and 13 months before developing hyperglycemia and glycosuria necessitating changing to other forms of treatment. This problem of secondary failure was noted in 7 per cent of the subjects reported on by Pfeiffer, *et al.*[16] They were unable to find other causes of the failure such as dietary indiscretions, operations or infections. In our four secondary failures, the dosage was not increased above 1 Gram daily. This might justifiably be criticized. Dolger,[17] however, reported very little success in achieving control by elevating the dosage above the usual maintenance level of 1 to 1.5 Gram daily. Other authors,[18,19,20] note that higher dosage is necessary in some patients for control but give no statistics to indicate degree of success when higher dosage is given. A group of Scandinavian investigators [21] also noted secondary failures and found increasing the dosage of no effect.

AGE

ALL of the patients in this group were over the age of 40. The oldest was 81 and the youngest 41. Patients over the age of 40 generally show a much higher proportion of good response [22] to tolbutamide than do younger patients.[18] In Table 1 the successes and failures have been classified in the age decades. No obvious "trend" is discernible. Sugar,[18] found essentially the same ratio of success in patients 40 to 59 years as in those over 60.

DURATION OF DIABETES

None of the five patients in whom the diabetic state had been recognized for at least 10 years prior to the use of tolbutamide showed a satisfactory response. See Table 2. Many authors[13,18] have noted the trend for higher incidence of failure in patients with increasing duration of diabetes.[20]

Others[22] have failed to confirm this trend.[19] The proper attitude in selection of patients according to duration of diabetes is well-expressed by Mehnert, *et al.*;[20]—"in dealing with maturity-onset type of diabetes, duration of diabetes need not be a contraindication to success with the orally given agent."

TABLE 1.

Age	Success	Failure	Success Ratio
40 - 50	2	4	33%
50 - 60	3	2	40%
60 - 70	3	2	40%
Over 70	4	2	66%
	12	10	54%

TABLE 2.

Duration of Diabetes	Success	Failure	Success Ratio
Less than 1 year	4	1	80%
1 - 5 years	4	2	67%
5 -10 years	3	1	75%
More than 10 years	0	5	None
	11	9	50%

PREVIOUS THERAPY

Patients who had not previously received insulin showed more success than those who previously required insulin, especially those receiving more than 15 units daily (Table 3), The literature is conflicting on this point. Mehnert, *et al.*,[20] noted success much more commonly in the patients who had *not* previously taken insulin or in whom the requirement had been less than 20 units daily. Others[22] have noted little,[19] if any, correlation.[18]

TABLE 3.

Previous Insulin	Success	Failure	Success Ratio
None	9	2	54%
15u. of less	2	1	67%
16u. of more	1	7	14%
	12	10	54%

TABLE 4.

Weight Change	Success	Failure	Success Ratio
Gain	2	0	100%
No change	4	6	40%
Loss	6	4	60%
	12	10	54%

WEIGHT CHANGE

Enthusiasm for a new form of treatment might lead to greater enthusiasm for following a diet and losing weight. This factor would then make an agent appear more effective than justified. In this series of ambulatory patients, accurate record of food intake was not possible. Only the weight record can be analyzed to see if weight reduction was a factor contributing to success. Two patients gained weight during treatment. Ten patients showed essentially no change (gain or loss of less than 3 pounds was not considered significant). Ten patients showed weight loss varying from 4 to 20 pounds. In Table 4, it can be seen that weight loss was *not* a factor in determining success in this series of patients.

TESTS OF RESPONSE

The 19 tolbutamide response tests were classified as "good" or "poor" as described by Camerini-Davalos, Marble and Root,[15] according to whether there was as much as 20 per cent decrease in blood sugar level 4 hours after the 3 Gram dose of Orinase®. Thirteen of the 19 so tested showed a "good" response. Of those 13, only 7 showed successful long-term results and 6 were classified as failures. Of the 6 patients who showed a "poor" response in the preliminary test, 3 had successful long-term management and 3 were failures. Thus, it can be concluded that the response test was of *no value* in prediction of long-term results in this series. Dolger,[17] also found of

little or no value a therapeutic test in which 60 milligrams of tolbutamide per kilogram of body weight were given orally followed by hourly blood sugar determination for five hours.

TOXIC MANIFESTATIONS

ALL patients in the series had complete blood counts, urinalysis, thymol turbidity and cephalin flocculation tests prior to and a few weeks following initiation of tolbutamide therapy. No evidence of hepatotoxicity or hematologic disturbance was found in any. In one patient the medication was discontinued after 8 months of successful treatment because of "weakness" which, the patient thought, was secondary to the tolbutamide. No dermatologic problems arose in this group of patients. Bondy [23] noted that tolbutamide appears to be a benign medication unlike the closely-related carbutamide which has been withdrawn from the market in this country.

SUMMARY

1. Certain sulfonylurea compounds, including tolbutamide, exert a definite hypoglycemic effect in normal and diabetic man. The mechanism of action is unknown, but evidence favors action *via* influencing hepatic glucose synthesis or release.

2. In this series of 22 ambulatory diabetics treated for 1 to 17 months with tolbutamide, there were 12 whose long-term response could be termed successful and 10 in whom therapy was unsuccessful. Of the 10 failures, four were "secondary failures" occurring after many months of successful treatment. Since the 22 patients in this series had been screened so that no one with known contraindications was included, a success rate of 12 in 22 (or 54 per cent) does not speak well for the long-term results with this medication. Whether more secondary failures will occur at even later dates remains to be seen.

3. One can expect the largest ratio of successful control with tolbutamide in patients over 40 years of age who have required no insulin previously and with relatively short duration of diabetes; though patients need not be excluded from trial on the basis of any of these criteria.

4. Weight change during treatment did not appear to be a significant factor in determining success in this series.

5. The tolbutamide response test appears to be of no value in predicting long-term results of treatment.

6. No evidence of toxicity due to tolbutamide was noted in this series and no serious toxic effects have been reported in the literature.

CONCLUSIONS

TOLBUTAMIDE is a safe, orally-administered agent of definite but limited value in the treatment of diabetes mellitus. It seems worthy of trial in diabetic patients past 40 years of age with relatively short duration of diabetes and low insulin requirement. The physician must expect a fairly high incidence of failures of treatment, both initially and secondarily.

The author expresses his gratitude to Alexander Keyssar, M.D., for permission to review these cases and to Otto Brandman, M.D., for helpful suggestions in the writing of this paper.

281 Kearny Avenue

A bibliographic list of 23 citations appears in Dr. Oyer's reprints.

R. Wendell Ward, M.D.
James B. Gere, M.D.
South Orange

Tumors of the Small Intestine*

Small malignant lesions of the jejunum and ileum are missed too often. Evidence indicates that such carcinomata are becoming more frequent. Dr. Ward and Dr. Gere here offer some diagnostic suggestions and cite an illustrative case.

Recently there has been heightened interest in tumors of the small intestine because of an apparent increase in the incidence of such lesions. The Mayo Clinic [1,2] reported 108 malignant tumors and 41 benign tumors of the small intestine in a thirty-year period. Fraser [3] listed thirteen malignancies of the small bowel in 22,795 gastrointestinal operations and 2,674 autopsies covering a ten-year period. An incidence of almost 0.1 per cent has been reported from one large autopsy series.[4]

Most large series originate from the well known teaching centers. It is the purpose of this paper to review the experience of a general community hospital over a ten-year period. The important clinical, radiologic and pathologic features of small intestine tumors will be discussed.

Since the clinical picture of duodenal tumors differs significantly from that of lesions of the remainder of the small bowel, only lesions of the jejunum and ileum are included in this study. The incidence of malignancy of this portion of the small bowel approximately equals that of the duodenum.[5] Sarcomas were not included if any other possible site of origin was present at the time of diagnosis.

Twelve tumors of the jejunum and ileum were collected in the ten-year period beginning July 1, 1949. All were malignant. Most reports from other centers indicate that 30 per cent of such tumors are benign. Seven of the 12 cases were male. Patients' ages ranged from 44 to 78 years at the time of diagnosis. The 44-year old was the only one under the age of 50. Eight were diagnosed within six weeks of the onset of symptoms. The remaining four had had symptoms suggestive of a small bowel tumor for from three to eighteen months.

The tumors were classified as follows:

Adenocarcinoma	7
Lymphosarcoma	2
Fibrosarcoma	2
Leiomyosarcoma	1

Gastrointestinal bleeding and intestinal obstruction are the two chief clinical pictures presented by patients with small bowel tu-

*From the Departments of Medicine and Pathology of the Hospital Center at Orange, New Jersey.

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5. McComb, A. R. and Pridgen, J. E.: Ann. of Surgery, 145:665 (May) 1957.
6. Patterson, J. F., Callow, A. D. and Ettinger, A.: Annals of Internal Medicine, 48:123 (Jan.) 1958.

mors.[6] One or the other of these usually predominates, although both may be present in any one patient. Perforation of the tumor with subsequent peritonitis may occur but is uncommon.

The bleeding of benign tumors is frequently intermittent and severe. The bleeding of malignant tumors is usually occult. A significant anemia is seen in approximately 50 per cent of cases. Although six cases in this series were anemic (hemoglobin below 12 Grams in males and 10 Grams in females), only one of them noted melena. Two cases presented themselves because of anemic symptoms.

Symptoms suggesting small bowel obstruction are a more common presenting complaint than symptoms of anemia. Recurrent, intermittent, crampy peri-umbilical pain, frequently relieved by vomiting, is characteristic of these cases. Crampy abdominal pain was present in 10 of the 12 cases in this series. In eight the pain was severe, acute in onset, and resulted in prompt surgical intervention. In two cases mild and intermittent pain was present for six and eighteen months before diagnosis. In both of these, gastrointestinal series and repeated physical examinations were normal. It was not until weight loss and anemia were discovered that restudy of the gastrointestinal tract demonstrated the malignant lesion.

Weight loss is usually found when the lesion is malignant. However, only four cases in this series had lost more than ten pounds. Physical examination was usually unremarkable except in cases presenting either with severe anemia or acute intestinal obstruction. A palpable abdominal mass was infrequent although two cases in this series had palpable masses, one with a fibrosarcoma, one with a lymphosarcoma.

X-ray examination of the small bowel is the most useful diagnostic study. Failure to obtain a small bowel series in the presence of obscure gastrointestinal bleeding or crampy abdominal pain may result in a delay in diagnosis since the x-ray changes are usually characteristic. In this series contrast study of the small bowel demonstrated the tumor in four cases. In six, the study was not done because of acute obstruction or a complicating severe illness. In two cases, small bowel series were not done after barium enema and upper gastrointestinal series had been reported as normal.

No conclusions can be drawn from this small series concerning the mortality rate of malignant lesions of the jejunum and ileum. Five of these 12 patients died during this ten-year interval. One, with a lymphosarcoma of the jejunum was alive and well almost ten years after diagnosis.

There was no correlation between the histologic type of tumor and the clinical findings.

Ten were diagnosed in the five-year period beginning July 1, 1954, and only two in the preceding five-year period. During this ten-year interval there has been no significant increase in either the number of adult admissions or in the number of abdominal operations. The incidence of small bowel tumors appears to be increasing. It was disturbing to note the frequency with which the lesion was incurable at the time of diagnosis, since most of these cases had had symptoms for only a short time and the diagnosis usually established promptly.

CASE REPORT

A 74-year old man was admitted to The Hospital Center at Orange in September 1951 complaining of recurrent, crampy, midepigastric pain of three months' duration. The pain occurred postprandially, lasted for one to two hours and was occasionally associated with vomiting. There was no melena, hematemesis, weight loss, or change in bowel habits. Physical examination was within normal limits except for the presence of a round, tender, moveable, epigastric mass. The mass was approximately ten centimeters in diameter. Routine laboratory examinations were normal except for a hemoglobin of 11.2 Grams.

Gastrointestinal series (see figure) revealed a long, diagonal loop of small bowel in the left mid-abdomen which showed almost complete loss of normal mucosal folds. This loop measures 15.0 centimeters in length and seems to represent a portion of the lower jejunum. The lumen is fairly markedly widened, and the mucosal contours show multiple irregular and nodular-appearing filling defects which completely distort and largely destroy the mucosal pattern. The character and extent of the lesions strongly suggested the presence of lymphoma, probably lymphosarcoma of the jejunum.

Abdominal exploration was done in October 1951. Approximately 10 centimeters from the ileo-cecal valve, a large tumor mass was found involving the ileum for about 20 centimeters. Adjacent small

bowel was directly involved by extension of the tumor. Tumor was also present in the lymph nodes at the root of the mesentery. The liver, spleen and retroperitoneal lymph nodes were normal. The lesion was resected and an end-to-end anastomosis was done.

Microscopically this tumor was a lymphosarcoma with spread through the wall of the bowel to involve an adjacent loop of small intestine. The mesenteric nodes were also involved.

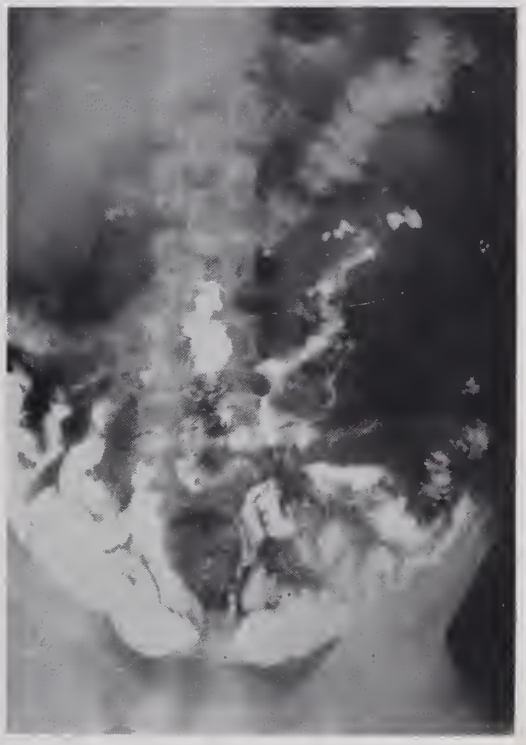
In May 1952 the patient was readmitted because of dysphagia. Enlarged lymph nodes were palpable in both supraclavicular and cervical areas. A fixed, 10 by 12 centimeter mass was palpable in the mid-abdomen. A hard, fixed, tender mass was present over the left ilium. A course of nitrogen mustard therapy was given and x-ray therapy started.

He was readmitted in September, 1952, having received x-ray therapy in the interim. Extensive disease was now present and death occurred two days after admission.

This patient presented with a large but apparently localized and resectable lymphosarcoma of the ileum. Widespread disease was present within six months of diagnosis and death occurred only fifteen months after onset of symptoms.

SUMMARY AND CONCLUSIONS

THIS paper has reviewed the experience of a general community hospital with malignant lesions of the jejunum and ileum. Although there were a variety of histologic patterns, the predominant clinical picture was one of either intestinal obstruction or gastrointestinal bleeding. Roentgenographic contrast study of the small intestine should be done in all cases of obscure iron deficiency anemia. These lesions were frequently far advanced by the time the diagnosis was established. This series suggests that tumors of the jejunum and ileum are increasing in frequency.



Gastrointestinal series showed a long, diagonal loop of small bowel in the left mid-abdomen with almost complete loss of normal mucosal folds.

120 Prospect St. (Dr. Ward)
452 Berkeley Ave. (Dr. Gere)

The Pattern of M.D. Visits

Age and sex play a role in the number of physician visits paid in this country, according to the May 1959 *Patterns of Disease*, prepared by Parke, Davis & Company. Women use physician services more frequently than men. Also, ratio of physician visits is highest for children under 5 years and for adults of both sexes in the 65-year and over age group.

The publication further reveals that 70 per cent of physician visits involve diagnosis and/or treatment of illness. Of such visits, two-thirds are related to chronic and one-third to acute illnesses. Ten per cent of visits are for general check-up, 7 per cent for immunization, and 4 per cent for prenatal and postnatal care.

Russell N. Carrier, M.D.

Robert S. Garber, M.D.

Cyril M. Franks, Ph.D.

Belle Mead

The Reactions of General Practitioners To a Psychiatric Abstracting Service*

The growing interest in psychosomatics—and in emotional aspects of general practice—will prove sterile unless some technic is devised for giving practitioners insight into psychiatric concepts. The success of one such program is here appraised.

In the spring of 1957 seminars on *Psychiatry for the General Practitioner* were sponsored by the Carrier Clinic in conjunction with the Mental Health Committee of The Medical Society of New Jersey and the New Jersey Chapter of the American Academy of General Practice. Abstracts of the 18 papers aroused so great an interest and brought such a demand for copies that, with the aid of Smith Kline and French, some 26,000 copies had to be printed and distributed throughout the country. Because of this widespread, and somewhat unexpected, interest an informal follow-up survey was carried out. It became readily apparent that, although the general practitioner was at times virtually inundated with pamphlets and literature of every description, there was a need for some form of abstracting service by means of which selected parts of the mass of technical psychiatric literature, written by one specialist for his equally special colleague, might be translated into more generally comprehensible language and consequently become of value to the general practitioner.

To meet this assumed need, the Carrier Clinic of New Jersey, in 1958, introduced a quarterly publication entitled *Abstracts of Psychiatry for the General Practitioner.* The first issue contained 30 one-page abstracts, culled from the recent world psychiatric literature. Some of the abstracts were relatively nontechnical summaries of highly technical research or clinical contributions; others were essentially sound, but not very technical, articles from a variety of sources not readily available to the general practitioner. Casual contact with a small sample of the 9,000 recipients suggested that many general practitioners would prefer the latter type of article, *i.e.,* strongly utilitarian and of immediate aid in their everyday practice. The second issue was modified accordingly and its articles were selected primarily on this basis. For example, topics treated in the second issue covered such diversities as the use of specific new medications, problems of addiction to tranquilizers, the psychiatric aspects of multiple sclerosis, the role of the psychiatrist in the treatment of Parkinson's disease, the differential diagnosis of momentary loss of consciousness, the psy-

*Read April 29, 1959 at the Annual Meeting of the American Psychiatric Association in Philadelphia.

chiatric symptoms masking brain tumor, the treatment of the neuroses in general practice, rehabilitation of the blind geriatric patient and the counseling of parents of mentally defective children. These topics raise problems which the general practitioner might well encounter in his daily routine.

At this stage it became apparent that the only way to evaluate and compare these two issues and to find out what the general practitioner really requires from an abstracting service—if he requires it at all—was to carry out a systematic survey. Accordingly, the research staff of the Carrier Clinic, with the partial aid of the Mental Health Education Unit of the Smith Kline and French Laboratories, selected 496 names at random from the 9,000 mailing list and sent out a brief questionnaire, accompanied by an explanatory letter and a stamped and addressed reply envelope. The questionnaire was anonymous and had only 10 items, some of which required a Yes/No type of reply, others a rating and some brief, written comments.

Of the 496 questionnaires sent out, only 52 were returned. This 10 per cent return is consistent with physician-reply ratios obtained under similar circumstances by other investigators. Second, the question now arises of how representative of the general sample of 496 are the 52 who replied. It might be speculated that only the more interested and therefore, perhaps, the more favorably disposed would bother to reply. To investigate this possibility, 30 additional randomly selected general practitioners were interviewed either directly or by telephone and essentially the same questions asked, but in considerably more detail. Although this new group is small, and hence subject to some reservations in drawing any conclusions, the trend of their replies did not differ significantly from those of the larger sample who responded to the written questionnaires. On the contrary, the resemblances were striking, suggesting that the 52 written replies may be judged as reasonably representative of *Abstracts* readers in general.

Of the 52 returned questionnaires two were blank, one because of the decease of the physician concerned and one for no apparent reason. Most of the remaining 50 questionnaires were fully completed. Hence the number of replies varied slightly from question to question. Most general practitioners recalled receiving both issues. A few recalled receiving neither. One respondent checked "neither" then, in an invited comment question, strongly complained of this failure to send him the journal and finally, in a question which called for suggested improvements, complained bitterly that the journal was "far too technical and complex." Fortunately such curious inconsistencies were rare and it was reassuring to observe that almost everybody who reported receiving both issues had taken the trouble to look at both issues.

Most of the replies were very much in favor of the *Abstracts* and their continuation, provided that the articles were of utilitarian value in general practice. Apparently what is required is guidance in a do-it-yourself program with some indications of its limitations and the sort of psychiatric cases and occasions when specialist help must be sought. Perhaps replies such as "helps me to evaluate and attempt to take care of patients that would ordinarily have to be sent to the psychiatrist immediately" are indicative of things to come. If so, not all psychiatrists will be as appreciative of this new service as are the general practitioners.

Comments were repeatedly expressed to the effect that the general practitioner is primarily interested in concise, practical articles which will be of value to him in his practice. He is not, in general, interested in keeping ahead of current research developments or new theories. Above all, he wants the articles to be abstracted in a language which is as devoid of technicalities or psychiatric jargon as possible, especially psychoanalytic terms. This veto does not apply to pharmacologic or general medical jargon; in other words, abstracts must be readily comprehensible to the general practitioner and utilize *his own* jargon, not any one else's.

From the Table it is clear that the *Abstracts* made some impact on those who received it.

The second, and more practical issue, was the more popular—although a surprisingly large proportion of readers apparently have no strong preferences. Both questionnaire and interview technics confirmed that the present format is very satisfactory in almost all respects and that a quarterly journal containing some 30 abstracts is "ideal."

One of the more revealing questions was that in which the physicians were asked to rank four different topic areas in order of interest and then add further comments if they felt so inclined. Both statistical ranking and additional comments indicate that there is a distrust and an aversion to many psychoanalytic concepts as well as a lack of interest.

A second Carrier Clinic Seminar Series of *Psychiatry for the General Practitioner* was held in the fall of 1958. Questionnaires were sent out to the general practitioners who attended the program. Eighty-nine questionnaires were sent out; 59 replies were received. The 12 questions were similar to those asked in the *Abstracts* questionnaire and, once again, strict anonymity was preserved. The information obtained from this questionnaire was intended to help in the presentation of an even better third seminar series in the future. Since the 89 recipients were already sufficiently interested in psychiatric problems to take the trouble to attend the preceding seminar series, they can, in no sense, be considered a random sample from the population of general practitioners. It is therefore hardly surprising, to learn that over 90 per cent of the replies indicated strong interest in psychiatric problems and a desire to receive further material provided that it were prepared specially to meet their needs. What is of significance is the answers received to questions concerning specific topics for future discussions. The needs expressed here coincided almost precisely with the needs expressed in the *Abstracts* questionnaire and many suggestions obtained which would be of value in the future planning of both Seminars and *Abstracts*.

A strong interest was expressed in the many problems associated with the management of the mental defective and his relatives. Other physicians were concerned about their lack of knowledge of the subtleties of office interview and treatment technics. One doctor wrote: "I feel a little inadequate in office interviews, where my stethoscope, thermometer, and examination table are removed. Also, in treament, where my hypodermic needle, prescription blank, and the like, are taken away. What can you do to help me? Your course has already helped a lot and your publicity angle with the newspapers has let many of my former patients know I was interested. They now come expecting more time and interest. What can you do to help me further in helping these people?"

In the *Seminar Survey*, as in the *Abstracts Questionnaire*, it became apparent that, as a group, general practitioners are primarily in-

TABLE 1.

STATISTICAL ANALYSIS AND SUMMARY OF REPLIES TO ABSTRACTS QUESTIONNAIRE

(N = 50)

Item	Percentage
a. Recalled receiving copy of Journal	94
b. Read or scanned copy of Journal	92
c. Believe that abstracted articles should be more utilitarian and cover less technical subjects:	
Yes	34
No	52
No opinion	14
d. Found second issue of more interest than first	26
Found first issue more interesting	6
No difference	30
Item not completed or not applicable	38
e. Too many articles abstracted per issue	19
Too few articles abstracted per issue	5
About right	76
f. Would welcome an article on when to refer a psychiatric problem elsewhere	96
g. Would welcome an article on state and voluntary commitment laws and procedures	84
h. Ranked order of interest of the following four topics:	
1. Psychosomatic medicine	47*
2. Treatment of psychiatric patients by the general practitioner	15*
3. Drugs	6*
4. Psychoanalysis	1*

*Note: These figures are not percentages, they are obtained as follows: For each topic the number of times the topic was placed first was divided by the number of times it was placed last. These four ratios were then expressed in terms of the smallest as unity by dividing throughout by the smallest, the final figures being corrected to the nearest whole number.

terested not in research, in theoretical principles or in abstract cases but in specific problems, their recognition and their treatment.

Returning now to the *Abstracts* questionnaire, many useful suggestions were received. Although most physicians were apparently satisfied with the existing procedure, several suggested that each issue be confined to one or two subjects which could be treated more thoroughly. Other specific suggestions occurring more than once were for the inclusion of articles on the therapeutic use of hypnosis, on the management of problems relating to mental deficiency, on medico-legal problems pertaining to mental abnormality, on the differential diagnosis of retarded, brain damaged and schizophrenic children and articles on the treatment by the general practitioner of specific disease entities and specific psychiatric problems, especially the mildly neurotic patient.

Several physicians commented sadly that their medical school training had provided them with little or no psychiatry and that this gap became more apparent as their office practice increased. What many physicians apparently require is some guidance in interviewing technics and the methods by which danger signals may be recognized in time. One problem which seems to arouse much anxiety in the general practitioner is that of the patient's anxiety, how to avoid its arousal and how to cope with such situations when they occur. An associated problem is how best to avoid "manipulation" by certain patients.

RUNNING through the responses to the *Seminar Survey, to the Abstracts Questionnaire* and to the direct interviews were a small number of comments pertinent to the general practitioner's personal reactions and to the gradual development of insight following exposure to basic psychiatric concepts and modes of thought. One general practitioner, although not in these words, discussed the problems of counter-transference and the gradual realization of the important part that he himself played in the treatment of a particular patient, even though the ailment was primarily a physical one. This was particularly brought home to him during one period when he did not feel well himself and was consequently inclined to be terse and irritable in his dealings with patients. Gradually he awakened to the fact that his patients were getting very little out of their visits to him on these occasions and that they weren't even responding to simple suggestions about taking their medication. He went on to report how meaningful it was to begin to understand his own emotional attitudes towards his patients.

Another physician commented that he was now able to recognize that he became persistently annoyed with a particular patient whom he had hated for many years. As a result of the literature he had read and the *Seminars* he had attended he is now able to realize much more clearly what had been happening between himself and the patient he had despised so much. This physician further reported that, with his change of attitude, he was able to sense a positive response on the patient's part.

A number of general practitioners reported that they felt terribly guilty about seeing patients with psychiatric problems or confirmed neurotics. They recognized that actually they did not want to see these patients and they felt uncomfortable about carrying patients along for a prolonged period of time and giving them nothing more material than "talk" to help them with their illnesses. Each of these practitioners then said that he is now more aware of his necessary role in the patient's treatment. Each added that, since he has reattained this awareness, he has been able to change his own attitudes towards his patients. The first practical step taken as a result of this developing insight was a rescheduling of office visits to allow more time for discussions of the many emotional factors involved.

THE report of one physician is worthy of direct quotation. It reads as follows: "I have been doing many of these things in my relationships with my patients all my life and never gave myself any credit for it. Now that I have some understanding of the mechanisms involved I am certainly going to give myself credit—so now I like myself better."

CONCLUSION

1. The Carrier Clinic *Abstracts of Psychiatry for the General Practitioner* seems to be fairly successful in meeting a recognized need by the general practitioner for practical information and guidance about commonly encountered psychiatric disorders. It is apparently also serving a function which is not quite as well recognized as a need by the average general practitioner—namely the need to develop partial insight into personal reactions and into doctor-patient interactions regardless of the nature of the presenting complaint.

2. The editors and abstracting committee would be advised to develop their searching and abstracting technics in two different directions. *First,* they have to recognize that a wealth of practical material of direct value to the general practitioner sometimes lies obscured beneath a mass of technical detail, and highly professional idiom is frequently intelligible only to the specialist and his specialized cohort—and sometimes not even to them. It is the task of the editors to discover, translate and edit the relevant portions of these articles and present them to the general practitioner in readable, yet still accurate, form. *Second,* they have to seek out, condense and collect under one roof the more significant of those non-specialist psychiatric articles which lie scattered from time to time throughout the 5,000 or so medical journals which appear regularly somewhere in the world. Here the problems are primarily those of wise selection and good condensation.

3. From the point of view of prospective authors the urgent need seems to be for concise and up to date information on the various problems associated with state and voluntary commitment procedures for mental patients. The other area where more articles are required is that of practical "know-how"—a sort of do-it-yourself manual for the family physician who has to cope with a wide variety of direct and reactive neurotic conditions in his general practice. Included in this latter type of article would be the provision of information and warning signs which might advise the physician when to consider seeking more specialized psychiatric help elsewhere.

The Carrier Clinic

Nursing by Degrees

Last June, for the first time in the history of higher education there were more degree nurses (5,155) among the country's 88,000 college women graduates of that year than any other professional group except teachers.

Six months after receiving their degrees, all but 2 per cent of these collegiate nurses who wanted work had found it. Their starting salaries averaged $3,875 and placed them sixth among 23 listed occupational groups. *They were earning $76 a year more than teachers and $136 more than the average of all employed women college graduates.* Those aged 22 and younger started at an average of $3,543 and those 23 and up (many of whom had had previous nursing experience) started at $4,057.

In the past two years, nursing has skyrocketted from fifth to second place among the occupational fields that the most college women entered in the years since 1955, passing those in "miscellaneous professional work," "miscellaneous clerical work" and "secretarial and stenographic work." While the percentage of women graduates entering teaching decreased from 61 per cent of the total in 1955 to 58, those entering nursing increased from 4 to 7 per cent.

Offices to be Filled by Election

1960 Annual Meeting

Office		*From*		*To*		*Incumbent and County*
President-Elect	1 year	May	1960	May	1961	Jesse McCall, Sussex
First Vice-President	1 year	May	1960	May	1961	Ralph M. L. Buchanan, Warren
Second Vice-President	1 year	May	1960	May	1961	Louis S. Wegryn, Union
Secretary	1 year	May	1960	May	1961	Marcus H. Greifinger, Essex
Treasurer	1 year	May	1960	May	1961	Rudolph C. Schretzmann, Bergen
Trustees: (*) Second consecutive full term expiring; ineligible for re-election.						
2nd District	3 years	May	1960	May	1963	(*)Joseph P. Donnelly, Hudson
3rd District	3 years	May	1960	May	1963	(*)L. Samuel Sica, Mercer
4th District	3 years	May	1960	May	1963	(*)Reuben L. Sharp, Camden
11th Trustee	3 years	May	1960	May	1963	Joseph R. Jehl, Passaic
Judicial Councilors:						
1st District	3 years	May	1960	May	1963	Emanuel M. Satulsky, Union
4th District	3 years	May	1960	May	1963	Daniel F. Featherston, Monmouth
A.M.A. Delegates:						
	2 years	Jan.	1961	Dec.	1962	J. Wallace Hurff, Essex
	2 years	Jan.	1961	Dec.	1962	C. Byron Blaisdell, Monmouth
	2 years	Jan.	1961	Dec.	1962	Elmer P. Weigel, Union
	2 years	Jan.	1961	Dec.	1962	L. Samuel Sica, Mercer
A.M.A. Alternates:						
	2 years	Jan.	1961	Dec.	1962	Herschel Pettit, Cape May
	2 years	Jan.	1961	Dec.	1962	John H. Rowland, Middlesex
	2 years	Jan.	1961	Dec.	1962	Ralph M. L. Buchanan, Warren
	2 years	Jan.	1961	Dec.	1962	Jesse McCall, Sussex
Delegates and Alternates to Other States:						
New York:						
Delegate	1 year For 1961 Convention					William F. Costello, Morris
Alternate	1 year For 1961 Convention					Levi M. Walker, Atlantic
Connecticut:						
Delegate	1 year For 1961 Convention					Lloyd A. Hamilton, Hunterdon
Alternate	1 year For 1961 Convention					S. Eugene Dalton, Atlantic
Administrative Councils: (Appointed by the Board of Trustees for 1959-60 in conformity with new Bylaws)						
Legislation: (2 for 1 year; 2 for 2 years; and 2 for 3 years)						
First District	1/2/3 yrs.	May	1960	May	1961/2/3	Elbert H. Pogue, Union
Second District	1/2/3 yrs.	May	1960	May	1961/2/3	Winton H. Johnson, Bergen
Third District	1/2/3 yrs.	May	1960	May	1961/2/3	A. John Bambara, Hunterdon
Fourth District	1/2/3 yrs.	May	1960	May	1961/2/3	Frank J. Hughes, Camden
Fifth District	1/2/3 yrs.	May	1960	May	1961/2/3	John S. Madara, Salem
Sixth Member	1/2/3 yrs.	May	1960	May	1961/2/3	H. Hale Hollingsworth, Passaic
Medical Services: (2 for 1 year; 2 for 2 years; and 2 for 3 years)						
First District	1/2/3 yrs.	May	1960	May	1961/2/3	Albert Abraham, Morris
Second District	1/2/3 yrs.	May	1960	May	1961/2/3	Louis A. Amdur, Hudson
Third District	1/2/3 yrs.	May	1960	May	1961/2/3	Durant K. Charleroy, Mercer
Fourth District	1/2/3 yrs.	May	1960	May	1961/2/3	Willis B. Mitchell, Ocean
Fifth District	1/2/3 yrs.	May	1960	May	1961/2/3	Charles B. Norton, Jr., Salem
Sixth Member	1/2/3 yrs.	May	1960	May	1961/2/3	Donald B. Hull, Bergen

Public Health: (2 for 1 year; 2 for 2 years; and 2 for 3 years)

First District	1/2/3 yrs.	May	1960	May	1961/2/3	Estelle T. Milliser, Union
Second District	1/2/3 yrs.	May	1960	May	1961/2/3	John P. Coughlin, Hudson
Third District	1/2/3 yrs.	May	1960	May	1961/2/3	Elmer J. Elias, Mercer
Fourth District	1/2/3 yrs.	May	1960	May	1961/2/3	George J. McDonnell, Monmouth
Fifth District	1/2/3 yrs.	May	1960	May	1961/2/3	Gene N. Schraeder, Atlantic
Sixth Member	1/2/3 yrs.	May	1960	May	1961/2/3	William Furst, Essex

Public Relations: (2 for 1 year; 2 for 2 years; and 2 for 3 years)

First District	1/2/3 yrs.	May	1960	May	1961/2/3	Edward G. Bourns, Union
Second District	1/2/3 yrs.	May	1960	May	1961/2/3	Robert S. Weinstein, Sussex
Third District	1/2/3 yrs.	May	1960	May	1961/2/3	Gerard R. Gessner, Middlesex
Fourth District	1/2/3 yrs.	May	1960	May	1961/2/3	Howard C. Pieper, Monmouth
Fifth District	1/2/3 yrs.	May	1960	May	1961/2/3	Josiah C. McCracken, Jr., Atlantic
Sixth Member	1/2/3 yrs.	May	1960	May	1961/2/3	William P. Mulford, Burlington

Standing Committees: Appointed by Board of Trustees for 1959-60 in conformity with new Bylaws)

Annual Meeting: (1 for 1 year; 1 for 2 years; and 1 for 3 years)

1/2/3 yrs.	May	1960	May	1961/2/3	Herschel S. Murphy, Union
1/2/3 yrs.	May	1960	May	1961/2/3	Raymond J. Gadek, Middlesex
1/2/3 yrs.	May	1960	May	1961/2/3	Peter H. Marvel, Atlantic

Finance and Budget: (1 for 1 year; 1 for 2 years; and 1 for 3 years)

1/2/3 yrs.	May	1960	May	1961/2/3	Anthony J. Conty, Hudson
1/2/3 yrs.	May	1960	May	1961/2/3	Theodore K. Graham, Passaic
1/2/3 yrs.	May	1960	May	1961/2/3	Herschel Pettit, Cape May

Medical Defense and Insurance: (1 for 1 year; 1 for 2 years; and 1 for 3 years)

1/2/3 yrs.	May	1960	May	1961/2/3	John J. Flanagan, Essex
1/2/3 yrs.	May	1960	May	1961/2/3	John J. Bedrick, Hudson
1/2/3 yrs.	May	1960	May	1961/2/3	James F. Gleason, Atlantic

Medical Education: (1 for 1 year; 1 for 2 years; and 1 for 3 years)

1/2/3 yrs.	May	1960	May	1961/2/3	Francis J. Gilroy, Bergen
1/2/3 yrs.	May	1960	May	1961/2/3	Malcolm M. Dunham, Middlesex
1/2/3 yrs.	May	1960	May	1961/2/3	Ralph H. Van Meter, Burlington

Publication: (1 for 1 year; 1 for 2 years; and 1 for 3 years)

1/2/3 yrs.	May	1960	May	1961/2/3	Joseph E. Mott, Passaic
1/2/3 yrs.	May	1960	May	1961/2/3	Fred B. Rogers, Mercer
1/2/3 yrs.	May	1960	May	1961/2/3	C. Spencer Davison, Salem

Woman's Auxiliary: (1 for 1 year; 1 for 2 years; and 1 for 3 years)

1/2/3 yrs.	May	1960	May	1961/2/3	George O. Rowohlt, Bergen
1/2/3 yrs.	May	1960	May	1961/2/3	Lester A. Barnett, Monmouth
1/2/3 yrs.	May	1960	May	1961/2/3	A. Guy Campo, Gloucester

Trustees' Meeting, January 17, 1960

Following is an abstract of actions taken January 17, 1960 at the regular meeting of the Board of Trustees held that day.

It was announced that Mrs. Asher Yaguda has been appointed chairman of the State Advisory Committee, White House Conference on Aging. Dr. Bowers has accepted vice-chairmanship of that committee.

An invitation has been received for the Society to nominate three other physicians for the New Jersey Scholarship Committee, Dr. Bowers is currently on the committee—one of whom will be invited to serve. It was suggested that nominees *not* be members of the teaching staff in any medical school.

Upon motion, the President was authorized to submit three nominations in addition to his own name.

Subsequently, the President submitted the following nominations:

Vincent P. Butler, M.D., Jersey City
John F. Kustrup, M.D. Trenton
Joseph E. Mott, M.D., Paterson
F. Clyde Bowers, M.D., Mendham

The liaison official of the Society to the State Department of Health, Dr. Elias, reported to the President that the Health Department proposed a pilot program to TB test the children in kindergarten and grade 1 in 9 cities. He suggested that the Health Department communicate with the county societies involved in the "9 testing cities" and obtain a true opinion from the physicians, including school physicians, concerning the TB testing in their schools. It was agreed that Dr. Elias' recommendation to the Health Department be approved.

An organization meeting of a Council on Health Care of the Aged was held on January 10, 1960. Representatives were present from the New Jersey State Dental Society, New Jersey State Nurses' Association, Licensed Nursing Homes Association of New Jersey, New Jersey Hospital Association, and The Medical Society of New Jersey. The group voted to establish a Joint Council. Dr. Hahn was elected chairman; and Dr. Eckstein secretary. A planning committee was appointed (with representation from each organization) to map out a program of study to be followed leading to a positive program. Communications announcing the establishment of the Joint Council will be sent to the State Chamber of Commerce, the State Division of Aging, the Governor, the National Council, and the State Department of Health.

The Executive Officer has been invited to join the 1960 Welfare Conference Planning Committee. Suggested topics for the Conference, to be held in Asbury Park, October 25-27, 1960, include "Progressive Patient Care," the "Need for a Second Medical School in New Jersey," and "Alcoholism in Industry."

Because of the professional character of the subjects under consideration, Mr. Nevin suggested that a physician might serve the Society better than could the Executive Officer as a member of the Planning Committee.

With the consent of the Board, the chairman appointed Dr. Jehl as the Society's representative on the Conference Planning Committee, and directed that the Council be so notified.

A Conference, sponsored by the AMA Committee on Medical Practices, will be held on March 26, 1960, in Washington, D. C. Representatives from the following medical societies are invited to attend: Delaware, Maryland, New Jersey, North Carolina, Pennsylvania, Virginia, West Virginia, and District of Columbia.

On motion, the following representatives were authorized to attend with expenses paid: President-Elect (Dr. McCall), Chairman of the Council on Medical Services (Dr. Klompus), and one member of the Council selected by its chairman.

At the request of the special Committee on Testimony, Dr. Kaufman has been appointed as a member by the Chairman of the Board of Trustees.

Because the Court's Committee, of which Judge Clapp is chairman, is so large it would be cumbersome, the Chief Justice has decided to appoint a special committee of five or six members to meet with the Society's committee on the question of impartial medical testimony. The preliminary meeting of the Court's committee will be held on January 18, 1960, after which a joint conference will be arranged.

Notice has been received that in consequence of the resignation of A. Russell Sherman, M.D., there will be a vacancy on the Board of Managers of the State Commission for the Blind. An invitation was received by the Society, through the State Board of Control, to submit nominations for a successor to Dr. Sherman.

The Board expressed its conviction that, in the interest of the public welfare, only an ophthalmologist should succeed Dr. Sherman.

Upon individual motions, seconded, and carried, the following nominations were approved:

1. Charles E. Jaeckle, M.D., East Orange
2. William H. Hahn, M.D., Newark
3. Vincent A. Burell, M.D., Phillipsburg

The final cost accounting for the Medicare Program operation in New Jersey shows a due bill of a little over $10,000, which includes $400 due the Society for expenses incurred by the special committee. This is the difference between the budgetary allowance and the final cost of all claims.

The accounting has been reviewed by Medical Service Administration and found to be correct. Authorization for the proper officers of the Society to sign the supplemental agreement was requested.

It was agreed that the proper signatures be affixed to the papers.

A resolution from the Cumberland County Medical Society disapproved of a proposal to dispose of Philadelphia refuse on a New Jersey shore in an area known as "Round Island" —adjacent to Government-owned Wild Life Preserve and Sanctuary; site of a healthy re-seeding oyster bed; and source of well-water supply. The resolution requested the State Society's supportive action and notifica-

tion of such action to the State Board of Health.

Dr. Ware reported that since the adoption of the resolution, the Governor had reviewed the situation and had started condemnation proceedings for purchase of the area for the State Fish and Game Commission. Dr. Ware suggested that the resolution be approved and that a letter be sent to the Governor thanking him for his stand and assistance in solving the problem. The resolution was approved.

It was agreed that the Governor be commended for his action.

In response to the Board's communication (meeting of November 15, 1959) recommending to the Editor of the *AMA News* that questionnaires, such as the recent one on travel, be discontinued and discouraged—a copy of which was sent to Dr. Blasingame, Executive Vice-President of the AMA—Dr. Blasingame explained the reason for such questionnaires. ". . . The value of the information obtained through these questionnaires flows from the fact that as a matter of policy the AMA is attempting to finance the publication of the *AMA News* through the sale of advertising to non-pharmaceutical industries . . . We must be in a position to demonstrate that readers of this newspaper are interested in the products they manufacture, and the only way to obtain the information is to periodically question the readers themselves . . ." Dr. Blasingame further stated that, if the Board believes the value derived from the questionnaires is not worthwhile, all physicians from New Jersey can be eliminated from subsequent mailings. He requested he be so notified if this is so.

Dr. Donnelly, who originally brought the matter before the Board, stated he did not feel that advertising would be lost without questionnaire information; and he suggested that New Jersey physicians be eliminated from questionnaire mailings.

Dr. Allman stated he did not believe all members should be deprived of participating in such programs if they want to; if they don't want to participate they need not reply and furnish the information.

Dr. Bowers moved—seconded by Dr. Donnelly, and carried; Dr. Allman voting in the negative—that the Board reaffirm its previous action (November 15, 1959—that the Board of Trustees recommend to the Editor of the *AMA News* that questionnaires, such as the recent one on travel, be discontinued and discouraged.)

Resolutions of opposition to the Blue Cross Rider for Diagnostic Services (similar to the Hudson County resolution endorsed by the Board on November 15, 1959) were received from the Mercer, Passaic, and Somerset County Medical Societies.

With the consent of the Board, the chairman directed that the resolutions be received and noted.

Received and noted was a communication from the National Chamber of Commerce stating that the Medical Society had been elected to membership. Also received and noted was a membership certificate which the office had had framed and hung on the wall in the Board Room.

An invitation was received from the State Chamber of Commerce for representatives to attend National Chamber's "Aircade for Congressional Action" in Newark on February 18, 1960. This is one of "a nationwide series of discussion-type meetings on major legislative issues affecting business and how businessmen can work more effectively in the political party of their choice."

The communication was referred to Dr. Blaisdell as Chairman of the Council on Legislation, who indicated his willingness to attend.

Received and noted was an acknowledgment of the Board's letters to Medical-Surgical Plan concerning actions in respect to an independent MSP public relations counsel and to the recommendation for full membership of the President of the Society on the Board of MSP. The matters will be considered by the MSP Board at its meeting on January 26, 1960.

Received from the Judicial Council was a reply to the Board's referral concerning the utilization by New Jersey physicians of "Package Plan" services offered by an out-of-state bio-analytical laboratory. The Council directed attention to its earlier opinion, officially reported to the Board and to all county medical societies in January, 1959, in which the Council declared that "the utilization of this service is in itself not unethical. However, it would caution member-physicians of The Medical Society of New Jersey to be certain that the services of the . . . laboratory are scientifically dependable and that the charge reflected in the patient's bill is reasonable and proportionate with relation to the cost to the physician for the services rendered." At its meeting on January 10, 1960, the Council reaffirmed this opinion.

The Council directed that all correspondence relating to this matter be returned to the Board, with the recommendation that the Board of Trustees send to the State Board

of Medical Examiners the complete file of material. It was determined that the entire file of material on the matter be referred to the State Board of Medical Examiners, in accordance with the recommendation of the Judicial Council, for whatever action the State Board deems necessary.

As directed by the 1958 House of Delegates, a bill was introduced into the 1959 Legislature at the request of the Medical Society by Senator Ridolfi (S-147—to permit school medical inspectors to accept the report of a physical examination made on a pupil by his treating physician in lieu of the examination required to be made by the school medical examiner or school nurse.) The bill bogged down in committee and was not acted upon.

Dr. Blaisdell requested the Board's directive as to whether or not the bill should be re-introduced into the 1960 Legislature.

Dr. Jehl moved—seconded by Dr. Wegryn, and carried—that the Board re-affirm the recommendation of the Special Committee on Child Health that such amending legislation be enacted, and that the Council on Legislation be instructed to re-introduce the bill in 1960 and endeavor to secure its passage.

In view of the opinion of legal counsel that the objections of the radiologists do not warrant interference with the proposed amendment to R.S. 45:9-21(k), to include pathology and radiology technicians, as recommended by the Council on Legislation, Dr. Blaisdell requested the Board's directive as to whether the amending legislation was to be introduced at this time.

Dr. Bowers stated that inasmuch as the matter had been referred back to the Board by the 1959 House of Delegates "for further study" and not with power to act, he felt the results of the further study should be reported to the House and introduction of legislation should not be made at this time.

Dr. Gardner moved—seconded by Dr. Kaufman, and carried—that the conclusions reached be made the subject of a resolution to the 1960 House of Delegates from the Board of Trustees.

Dr. Bowers suggested that Medical-Surgical Special Contract for the Aged was one positive step taken for the care of our older citizens. However, the necessary 51 per cent of our members have not so far signed as participating physicians. One of the objections is that a number of the 16 million over 65 can well afford the basic contract, though at the moment it is not available to those over 65. Dr. Bowers suggested that the basic contract might be more attractive for a certain number over 65, and offered the following resolution for the Board's consideration:

> Whereas, Medical-Surgical Plan of New Jersey does not have available at present a salable policy for those over 65 years of age; and
>
> Whereas, a policy has been approved and is being prepared for persons over 65 with reduced incomes; and
>
> Whereas, even if such a policy is offered it will not be attractive to many of those persons whose incomes are above the stated income ceiling; therefore be it
>
> Resolved, that the Board of Trustees of The Medical Society of New Jersey request that the Board of Trustees of Medical-Surgical Plan of New Jersey with all possible speed make available to those over 65 years of age the basic contract, with whatever actuarial adjustment is necessary.

Upon motion by Dr. Bowers—seconded by Dr. Kaufman, and carried—the resolution was adopted.

A suggested letter to the Chairman of the State Commission on Aging, Mrs. Eone Harger, was presented by Dr. Blaisdell, setting forth the Society's objections to the "Report of a Special Committee to the New Jersey Commission on Aging" presented at the Congressional hearings on July 16, 1959. Official endorsement by the Commission of the report seems to be a conclusion unwarranted by available facts, creating an unfavorable approach to the planned conferences in the State leading up to the White House Conference on Aging in January, 1961.

Dr. Blaisdell moved—seconded by Dr. Kaufman, and carried—that a communication, such as that suggested, be sent to Mrs. Harger by the President with copies being sent to the Governer and members of the Commission on Aging. It was also suggested, and approved, that later a copy of the communication be made available to the State Chamber of Commerce, and that it be released to the newspapers.

Medicare of Posthumous Children and Pregnant Widows

The following communication was received from the Office of Dependents' Medical Care with respect to "Continued Obstetrical and Maternity Care After Husband's Death," OD-MC Letter No. 10-59:

"1. Effective 28 July 1959, the Dependents' Medical Care Program is revised as indicated below.

"a. A dependent wife eligible for civilian medical care, whose husband dies while on active duty, and who is pregnant at the time of his death, may be provided, from civilian sources at Government expense, the authorized obstetrical and maternity care including authorized postpartum care for the child.

"b. The widow will be required to surrender DD Form 1173 authorizing medical care in both civilian and uniformed services facilities and will be issued a new DD Form 1173 authorizing medical care in uniformed services facilities only.

"c. When appropriate, the official who issues the new DD Form 1173 wil provide the widow with a letter, in triplicate, indicating that:

> Notwithstanding the fact that the DD Form 1173 in her possession does not authorize medical care in civilian facilities, she is authorized obstetrical and maternity care from civilian sources at Government expense if it is determined that she was pregnant on (*Date of Husband's Death*).

"d. Possession of the letter, and identification of the individual is sufficient authorization for the required care without the possession of a DD Form 1173. Accordingly, the contractual requirements for completion of Items 6 and 7 of the claim form, DA Form 1863, are waived in these cases.

"e. A copy of the letter must be attached to the DA Form 1863 submitted by the civilian physician and/or hospital providing care under these circumstances.

"f. The widow shall have free choice between civilian and uniformed services facilities for the care authorized herein.

"2. This policy is effective 28 July 1959 and does not apply to deliveries before that date. The following example illustrates the type of cases that are covered. EXAMPLE: If a member (as defined in Section 1-103B of the cited Joint Directive) died on 15 November 1958 and his widow was, in the opinion of the attending physician, pregnant on that date, and is delivered on 1 August 1959, she and the child will be eligible for benefits described in paragraph 1, above, for the entire period of the pregnancy as well as authorized postpartum period.

"3. Claims of this nature, if otherwise proper and complete except for Items 6 and 7 of the DA Form 1863, are payable if the attending physician states that, in his opinion, the dependent was pregnant on the date of death as shown in the letter indicated in paragraph 1c, above, and a copy of this letter is attached to the DA Form 1863 submitted by the civilian physician and/or hospital for payment."

Medical Effects of Fall-Out

A report is now available of the world's first survey of the medical effects of radioactive fall-out. Prepared by Dr. Samuel Berg of Newark, it was published in the November 1959 *Military Medicine*. Our state has another interest in this. Harrison Martland was one of the pioneers in appreciating the medical effects of radiation—a fact properly mentioned in the article. While the supply lasts, readers may obtain reprints from Dr. Samuel Berg, 156 Roseville Ave., Newark (7) N. J.

Symposium on Medical Care in New Jersey — Past, Present, and Future*

The General Session was convened at 3:15 p.m., Dr. Gardner presiding.

THE PRESIDENT: Ladies and Gentlemen, it is a pleasure for me to welcome you here this afternoon to the General Session of The Medical Society of New Jersey. It will be in two parts. The first will be the inaugural address by our new President, Dr. Bowers; and this will be followed by a symposium on Medical Care in New Jersey—Past, Present and Future.

It is indeed a pleasure for me to welcome all of you here this afternoon and particularly to have the privilege of presenting to you the incoming President, with whom I have had the pleasure of working for several years. He is a physician who has much ability, much good judgment. He has strong leadership and he has an excellent grasp and understanding of the many problems which confront the medical profession.

It is my happy privilege to present to you the new President of The Medical Society of New Jersey—Dr. F. Clyde Bowers.

(Standing ovation)

(Dr. Bowers' inaugural address "Lead or Be Led" was published in the August, 1959 issue of this JOURNAL, page 484.)

THE PRESIDENT: Thank you very much, Dr. Bowers, for an inspiring address.

The second portion of the program will be a Symposium entitled "Medical Care in New Jersey—Past, Present and Future." Dr. Jesse McCall will be the Moderator.

Dr. McCall is the new President-elect of The Medical Society of New Jersey, and it is my pleasure to present him to you at this time. Dr. McCall. (Applause)

THE MODERATOR: Thank you, Dr. Gardner.

Officers and Members of The Medical Society of New Jersey, our Auxiliary, Distinguished Guests, Ladies and Gentlemen:

Undoubtedly, at no time in the history of modern medicine has there existed such a large number of individuals, social, political and economic groups that are ready, willing, and anxious to tell the medical profession how, when, where and for what to dispense their services. This expressed interest of the public is a remarkable one. I witnessed an example of this two weeks ago at the Governor's Conference on the Problems of the Aging. More than a thousand people crowded the War Memorial Building in Trenton to listen to a panel of speakers and to discuss at lunch the economic and the medical care of our senior citizens. The crowd, by the way, was so much greater than was apparently anticipated even by Governor Meyner that a $2.35 luncheon shrank to two half sandwiches, a cup of coffee and two tablespoons of ice cream. And we actually had one water glass to every three people.

I sat partly on the left of Clyde Bowers, which was totally uninteresting, and partly on the left of a social worker from Hudson County, whose name I don't know. It was so crowded that even the discussion was utterly impossible. I mention it only to point up the intense interest of everyone on how we conduct ourselves.

At this luncheon there was a sixty-three-year-old woman, the Chairman of the Department of Sociology at Sweetbriar College in Virginia, my old home State, who practically stole the show. Her topic was such a simple one: How to grow old gracefully.

Now, it seems to me that one of the charges that we have been trying to slow down or defend against in the medical profession has been one of not being able to grow older gracefully—being opinionated, touchy, defensive, inelastic in our thinking.

Just a few moments ago you heard Dr. Bowers, who keynoted his inaugural address with two rather important admonitions about our conduct in our practice. One, that we must lead or we are going to be led; and the second, that to maintain our position of grace in the community we must be willing to sit down and discuss our problems with appropriate groups.

Now, this conference today is actually a sit down and discuss type of approach. Its title is Medical Care in New Jersey—Past, Present and Future. We have a panel of distinguished experts who will approach this problem from four different angles. We have, first, an eminent, a beloved New Jersey physician who has been a dispenser of medical care for over forty years. We have a member of the insurance industry with a wide knowledge of the problems of underwriting medical care. Then we have an industrialist and a humanitarian who wants good medical care for him-

*General Session, 193rd Annual Meeting of The Medical Society of New Jersey, April 27, 1959.

self, for his family, his employees and the public in general. And then lastly, we have a representative of Mr. and Mrs. America, quite appropriately—the taxpayer.

After the panel have had their initial say without any disruption at all, there will be a question and answer period. If you have a question that you would like to identify for the panel for answer, just write it down. If you care to address it to a specific panel member, that would be appreciated, too. If you don't, you will be at my mercy because I will then have to direct it to what I think is the proper direction.

First on our list, a man whom I personally hold in the greatest of esteem and real affection, a man who has dispensed medical services for over forty years. He likes to consider himself as retired as of the last year or so—I suppose, if possible, to retire your physical body, but I doubt if he will ever be able to retire—a sharp and brilliant mind which is always dealing and thinking about the problems of medical care. He needs no introduction to this group at all—Dr. Royal Schaaf, a Fellow of The Medical Society of New Jersey, President of the Board of Trustees of the Medical-Surgical Plan of New Jersey. His topic will be Medical Care from the Point of View of the Practicing Physician. Dr. Schaaf. (Applause)

DR. R. A. SCHAAF: Viewing it as I do from the perspective of half a century, the subject of medical care in New Jersey—Past, Present and Future—is indeed a challenging one for me. Of the past, I shall speak with the nostalgic reminiscence so characteristic of senior citizens, who display the early signs and symptoms of senescence; of the present, with the confident assurance, acquired by close contact with the problem in its many aspects over a period of more than twenty years; of the future, although lacking clairvoyance and, as the Irishman said, with my future behind me, with cautious optimism, the restraint being due to my somewhat apprehensive perception of certain danger signals presently clearly visible on the not very distant horizon.

Seldom if ever, in the long and troubled history of the life of man on this planet, has the line of demarcation between the past and the present been so sharply and abruptly drawn as it was between the first and second thirty years of the present century. The inflationary bubble of the twenties burst on October 22, 1929, with shattering effect upon the people not only in the United States but in the World at large, as well. Literally overnight, we were plummeted from the zenith of buoyant optimism and economic well being—somewhat spotty to be sure—to the nadir of black despair and stark privation. Gone was the possibility of a "chicken in every pot" and "two cars in every garage." Gone were the abundant job opportunities. Gone was the plenty—food, clothing and shelter—to which we had become accustomed. Instead we were confronted with almost insoluble problems in the economic, social and political fields of which we had no previous conception, and for which we had no ready solutions. Among these, the problem of the distribution of medical care became one of great urgency and far reaching importance.

Prior to 1930 the cost of illness was a matter of little concern to the people and still less to physicians, by whom it was regarded as a topic unfit for discussion at meetings of the gentlemen's clubs that County Medical Societies then were—in fact even to have mentioned it would have been regarded as a boorish impropriety.

Hospitalization of patients for the most part was limited to those requiring surgical treatment and those suffering from critical illnesses such as pneumonia, diabetic coma, uremia and so forth. Most confinements were conducted at home.

Admissions to hospital for diagnosis practically never occurred. X-ray diagnosis was only in its formative period of development. Electrocardiography was still in its infancy. Clinical laboratory procedures were limited to routine blood counts, urinalysis, sputum examinations for tubercle bacilli, gastric analyses and examination of feces for parasites and blood. The Wassermann test was made by public health laboratories without charge and blood typing for transfusion came into general use only after 1925. Believe it or not, in the early twenties a single charge of three dollars made against each patient admitted was adequate to equip, staff and maintain one of the best hospital clinical laboratories then being conducted in this State—this laboratory charge covering all tests made during the particular hospital stay.

Hospital deficits were liquidated by donations from wealthy trustees. In one hospital with which I was associated, the president of the board would bring his check book to the annual meeting. He would say "Gentlemen, in the year just ending we incurred a deficit of forty thousand dollars. Here is my check for twenty thousand dollars—you may pro rate the balance among you." Before the meeting adjourned, the deficit had been wiped out. Such hospital financing, however, ended in the early thirties, partly because of the magnitude of the task of meeting the cost of hospital care for the greatly increased number of the needy, and partly because of the confiscatory—not to say punitive—income taxes levied against people of wealth who no longer had available to them funds in amounts that made possible such largess.

In the first three decades of the twentieth century there was little noticeable change in the pattern of the economics of medical practice as it had existed for centuries before. The rich man was expected to—and did—assume the burden of the cost of medical care to the poor man, by generous donations for the maintenance of hospitals and by the payment of large bills to physicians and surgeons for professional services to himself or his family. Except under strict underwriting and cancellation provisions, sickness and accident insurance coverage was not available, and when it was,

the premium rates were so high as to preclude its purchase except by persons of considerable affluence. During this period, however, three important innovations in the field of medical practice came into being in New Jersey: Workmen's compensation, in 1911; Medical care for veterans by the Federal Government after World War I, and "on the job" medical care for workers in large industrial plants and other organizations—the precursor of modern industrial medicine. Brief as it is, so much for medical care in New Jersey in the past.

The present began with the stock market crash of 1929. Organized medicine in the United States as represented by the American Medical Association and The Medical Society of New Jersey was, in retrospect, curiously inert in the face of overwhelming community need and in the assumption of its responsibility for the distribution of adequate medical care to all of our people. As members of organized medicine, for several years, we deluded ourselves with the notion that prosperity was "just around the corner" and, like Mr. McCawber, we waited with confidence for "something to turn up." Five years passed by, during which the Hospital Service Plan of New Jersey, the first state wide Plan of its kind in the United States, was established by laymen without the advice and guidance of The Medical Society of New Jersey, some of whose component county societies actually opposed the movement on the now incredible ground that it represented a step in the direction of socialized medicine. During this period the Federal Government established the Emergency Relief Administration one of whose functions was the distribution of medical care to the needy, of whom there were so many. This effort, however, was, in effect, actually a W.P.A. project, for physicians practicing in depressed neighborhoods who were rendering service to their patients who were quite unable to pay for it.

Finally the imminent threat of socialized medicine aroused us from our lethargy and we began energetically to develop a plan for voluntary prepaid sickness insurance. Tardy and reluctant as we were, we, in New Jersey, were well in the vanguard of the movement which eventually became nation-wide and known as the Blue Shield movement. Ours was one of the earliest if not the first of the State enabling acts for non-profit medical service corporations, having been adopted by the New Jersey State Legislature without a single dissenting vote in March 1940.

Under this statute The Medical Society of New Jersey proceeded promptly to establish the Medical Service Corporation which became known as the Medical Services Administration of New Jersey, and by which the Medical-Surgical Plan of New Jersey was formed. The latter organization began its operations on July 1, 1942 and all of you know its subsequent history and its present flourishing state. Amusing now, in the light of the uninterrupted success that has attended the operations of the Medical-Surgical Plan of New Jersey during the past seventeen years, but time consuming and aggravating at the time, was the semantic battle waged between the then elder statesmen of this Society and the Governors of Medical Service Administration—the former wishing only to "organize" the agency, the latter wishing to have it "sponsored" by the Society. After much travail the "pussy footers" won and to this day neither the Administration nor the Plan is "sponsored" by The Medical Society of New Jersey, although the Society has been most liberal in its financial support of the Medical Service Administration.

Probably the most remarkable economic development resulting from the Great Depression was that of voluntary prepaid sickness insurance, one of the most spectacular phenomena in the entire history of insurance of all kinds.

Commercial insurance companies did not enter the field to any extent until the many Blue Shield Plans had accumulated enough reliable statistical and actuarial data to make it safe for them to do so. At present, however, many of the great commercial insurance companies are offering excellent prepaid sickness insurance coverage, except for its service benefit feature, quite comparable to that offered by the Blue Shield Plans.

The latest addition to the sickness insurance program is major medical expense coverage, which, superimposed on good basic insurance, appears to be "just what the doctor ordered," provided it is not abused.

What of the future? In masterly fashion Doctor Bowers has sketched in general terms the dangers that threaten the continuance of the private practice of medicine as we know it and wish it to continue. As he pointed out, we must lead or be led. Organized medicine must offer acceptable alternatives to the inclusive medical service proposed by the Forand bill, for the hospital and medical care of the elderly and by the various socialized medicine bills for the entire population. The great danger in the Forand Bill, aside from the enormous increase in the tax burden that would result, lies in its "Trojan horse" approach to the establishment of socialized medicine for everyone. Once adopted, all Congress needs to do is to lower the age limit for eligibility by five-year steps each year—in twelve years complete socialization of medicine with all its attendant evils would be a reality! Have no doubt—the "Socializers" are definitely planning such an approach. How easy would it be! The alternative of voluntary prepaid sickness insurance is, of course, the obvious one. Much has been accomplished in this direction by the many Blue Shield Plans and the strong commercial insurance companies, but much more must be done. We, in New Jersey, have acted promptly in the development of a Medical-Surgical Plan contract adapted to needs of our senior citizens. The contract will be sold on an individual basis with underwriting restrictions but no cancellation feature. Everyone, upon attaining the compulsory retirement age of 65, is not sick or disabled, nor is he indigent or medically indigent. Neither has he lost his self respect and desire to pay for his own food, clothing, shelter and medical care, this last he will be able to do in most instances if a premium rate appropriate to his income is made available to him.

There will be many elderly people who are uninsurable, and these will require medical and hospital care by means now available throughout New

Jersey. Considerably more money must be alloted to this purpose out of general tax funds—municipal, county and state—but the administration must be at the municipal or, at the highest, the county level.

Many physicians honestly believe that they are entitled to make higher charges than they usually would, when patients have sickness insurance of some kind. Especially is this true when the patient is covered by major medical insurance. I have seen many bills for staggering amounts under major medical insurance—bills sent by surgeons, who, I know, would never make such charges were it not for major medical expense. If continued, such practice will bankrupt major medical funds, and the commercial insurance companies—now the only ones offering it in New Jersey—will be obliged to abandon this program. The doctor will have "killed the goose that lays the golden eggs!"

People who have—or whose employers have for them—prudently deposited money in a fund for sickness insurance protection, should not be penalized for their forethought and good judgment any more than if they had deposited their money in a savings bank to be available in case of need.

In conclusion, may I say that the preservation of private medical practice as we wish to have it continue, depends vitally upon the continuance and further development of voluntary prepaid sickness insurance—good basic Blue Shield, and/or commercial coverage with superimposed major medical expense coverage.

The attitude of this Society and of organized medicine in general must be one of dynamic conservatism—the words are not incompatible. We must initiate vigorously new and improved methods for the distribution of medical care, with the dignity of the individual constantly in mind and within the framework of the American concept of justice and the free enterprise system under which our Country has grown great.

THE MODERATOR: Thank you, Dr. Schaaf.

Dr. Schaaf has apparently already included in his closing remark a sort of defense of the insurance industry. However, we have, as I promised you, a member of the insurance industry who, I'm sure, is prepared to defend himself and his group.

Our next speaker is Mr. Robert R. Neal, General Manager of the Health Insurance Association of America. Mr. Neal. (Applause)

MR. NEAL: I accepted an invitation a few days ago to predict the important developments in the field of voluntary health insurance during the next ten years. My response was along these lines:

"Health insurance has been and for the next ten years will continue to be a significantly American social institution. It is an important factor in the American economy and will grow with it. The greatest enemy of both health insurance and the economy will be inflation.

"Through experimentation which will continue in the years ahead, health insurance will continue not only to grow but also to increase in its technical proficiency. More and better coverages will be available to the American people and particularly will this be the case in the areas of major medical and comprehensive insurance.

"The pattern of coverages will change also. This will be apparent—perhaps dramatically so—as the companies in the Health Insurance Association of America, in keeping with its purpose to promote the development of voluntary insurance, implement the resolution adopted by the Association last December relating to hospital, medical and surgical insurance.

"Insurers offering individual and family coverage for the cost of health care will minimize refusal of renewal solely because of deterioration of health after a policy has been issued. More and more insurers will make available to insurable adults policies which are guaranteed renewable for life. They will encourage the sale of permanent health care insurance where the need for that type of coverage exists. Individual and family surgical and medical care coverages will be readily available both to persons over the age of 65 and to broad classes of physically impaired people. Hospital, surgical and medical care coverages will be continued after retirement, either through continuing retired persons as a part of the original group or through their ability to convert their insurance on termination of employment.

"With medicine providing aggressive leadership, we will see the solution of many of the problems of medical economics. The American Medical Association, for example, is encouraging its constituent state associations to develop relative value schedules for various medical procedures, applicable to the local community and to serve as a guide to doctors, insurers and patients. These will undoubtedly emerge. Through continued experimentation, such as the programs in effect in San Joaquin County and in Long Beach, California, where physicians have bound themselves to abide by an arrangement which in effect announces to the public the price of service, irrespective of to whom rendered or by whom paid, great progress will be made. This will also be the case as physicians implement the American Medical Association's resolution recommending lower charges to the aged and cooperation with insurers in implementing low cost coverage for our senior citizens . . ."

Let's examine the ingredients of the prescription which will bring about this result. As a nation we are now enjoying the highest quality of medical care. This fact is reflected not only in longer life span but also in the increasing volume of hospital, physician and other services which make up the nation's health bill of more than 14 billion dollars.

This bill is paid by the consumer principally from two sources: (1) from earnings or savings and (2) our voluntary health insurance system.

Insuring organizations have the primary responsibility for (1) making coverage available to all who want and can afford to buy it, and (2) providing broad coverage at a reasonable cost.

The problem of financing hospital and medical care for the retired aged is of real concern, not

only because of its social and political significance, but also because it is the point on which the survival of our entire voluntary system of providing and financing health care may be resolved. It is here where implementation of the AMA's fine resolution adopted in Minneapolis and the principles adopted by the member companies of HIAA, to which I have referred, will be effective. You are, of course, entirely familiar with AMA's resolution.

As to the current status of voluntary insurance coverage for the elderly, the number of older people having some form of health insurance today is not known precisely. Generally, it is accepted that at least 40 per cent of persons over 65 now have some health insurance coverage.

There is an area which should be the government's responsibility. About 18 per cent of the aged are public welfare recipients under the federally aided public assistance programs and, as such, are eligible to receive health care. This group is and properly should be primarily the responsibility of State and local governments.

The complex and changing patterns of medical and hospital care with their increased cost are influencing the design of health insurance coverage. While in the main the insurance in force today still conforms to the basic hospital, surgical and medical care approach, a need has clearly emerged for more comprehensive coverage.

There are many variations in the details of how this need should be filled. However, within the insurance industry there is general agreement on the following principles:

(1) The plan should cover virtually all types of medical, hospital and other usual expenses which may be encountered during the course of an illness, recognizing the wide range of technical skills, medical technics and expensive drugs involved in modern medicine. In this way it avoids the situation where the form of coverage influences medical practice, e.g., in patient confinements for diagnostic purposes only.

(2) The insured should share in the total expense (exclusive of the premium) so that premium costs might be maintained at a reasonable level. The extent of his financial participation is determined by deductible and coinsurance provisions.

The deductible requires the insured to pay a stipulated amount (e.g., $25, $50, $100, etc.) of the initial covered expenses. In this manner, the lower cost illnesses which are relatively expensive to handle administratively are screened out, leaving the bulk of the premium dollar to cover the larger expenses of more severe illness which may be such a hardship to the individual.

Similarly coinsurance by requiring the insured to finance 20 per cent or 25 per cent of the expenses in excess of the deductible, discourages demands for luxury accommodations or other unnecessary services which would otherwise inflate premium costs beyond a reasonable level.

The need for the broader forms of health insurance protection is well established. Major medical insurance is one of several alternatives available to the public. The fact that major medical recognizes that primary responsibility for the quality of care rests with the providers of service, and otherwise supports the physicians' principles of the free practice of medicine, establishes a relationship between the success of major medical and your own personal interests. If you accept this analogy and the economic fact that survival of the comprehensive and major medical approach will be determined by its ultimate cost to the public, then the physician's and hospital's relationship to that cost becomes a prime consideration to you. Here you must not only consider the price of service to the consumer, but you must be acutely aware of the third parties who have a real interest in this area, for example, the employer and the union which have agreed on price or benefits at the bargaining table.

We have previously observed that the deductible and coinsurance principles establish financial incentives for the insured, which if they are effective, will enable cost to remain at a reasonable level. However, in order for them to be effective, there must be complete understanding and support among members of the medical profession and hospital field for these principles. Furthermore, it must be recognized that the practicing physician or surgeon has primary responsibility in controlling the quantity of medical services and establishing the fee for his services. To this extent, then, he directly oversees this part of the premium cost to the public. There is no intent to interfere in the normal patient-physician relationship as it affects quantity and cost of service. However, it is vitally important that both considerations be reviewed on criteria other than the existence or amount of insurance. Insurance is part of the third party mechanism. If the third party mechanism is ignored, insurance, especially major medical and comprehensive coverages, will be priced beyond the reach of the consumer and the demand for governmental control can follow.

The fundamental axiom is readily understandable if we examine a hypothetical case in which the existence of insurance is the only variable in an otherwise parallel set of circumstances.

Mr. A. and Mr. B. are at similar economic levels. They use the same services of the same physician for like illnesses. Mr. A. owns health insurance. Mr. B. does not. If Mr. A. is charged a higher fee solely due to the presence of insurance, the resulting higher charge for the insured class as a whole would ultimately argue against that form of prepayment, and for some other alternative which would exercise more control over the fee charged.

This situation is obviously an oversimplification of a very real problem. It is used merely to illustrate the direct relationship between physician's fees and insurance costs and why it is important that the physician establish his fee as if there were no health insurance in existence. Also it is a measurement of the effectiveness of different kinds of voluntary health insurance which is being used with increasing frequency by an informed public.

There is an important underlying difference between major medical and the basic forms of hospital and medical coverages which critics contend will in the long run serve to inflate the cost of medical care and ultimately price this form of

coverage out of the market. This is the fact that major medical relies on financial incentive such as deductibles and coinsurance and the medical profession's enlightened self interest rather than the built in controls which stem from the lower dollar limits and narrowed scope of insured services under the so-called "basic" forms of protection.

We cannot avoid coming to grips with this possibility, for it is indeed a vulnerable area. The integrity of the medical profession makes me confident that it will not become a reality. However, we must respond to this challenge together, with a full recognition of our relative responsibilities, and a willingness to fulfill them forthrightly.

On your part, there is a need to control and prevent inflation of costs, and particularly to prevent inflation from occurring merely because of the existence of insurance.

On our part, insurance has a responsibility to be of every reasonable assistance and to see that it does not directly or indirectly encourage practices which will result in increasing costs and price prepayment out of the market.

The statistics of insurance coverage reveal the public's demand for a mechanism through which a substantial portion of the cost of medical care may be financed.

It is inevitable that this demand will be filled. We are faced with the critical question of how this will be accomplished; whether through a government-operated or a voluntary system.

In Washington there are several significant developments which bear directly on this problem. You are quite familiar with the Forand Bill and similar proposals so I need not detail provisions here. You will recall that such proposals generally cover only hospital, nursing home and surgical care. However, Government will not long "pay the piper" without "calling the tune" and since Government must provide care for those hospitalized under a Government program, rules to govern the providers of that care will soon be forthcoming. The Supreme Court of the United States has enunciated the dictum that it is scarcely lack of due process for Government to regulate that which it subsidizes.

An important Congressional inquiry stems from the organizational meeting of the Senate Committee on Labor and Public Welfare. As usual, a Subcommittee on Health was created. In addition, however, a special subcommittee was organized, to be known as the "Subcommittee on Problems of the Aged and the Aging." The purpose of this Subcommittee is to study the whole field implied in its title. It is under the chairmanship of Senator McNamara of Michigan. Other members are, Senators Kennedy of Massachusetts, Clark of Pennsylvania, and Randolph of West Virginia, and Senators Dirksen of Illinois and Goldwater of Arizona. It is understood that an advisory board to the Subcommittee is to be appointed from industry and the public. It is generally believed that Dr. Wilbur J. Cohen, Professor of Public Welfare Administration, School of Social Work, the University of Michigan, will be chairman of such a board. Hearings will be held in Washington, but these will be relatively brief in comparison with the proposed 20 hearings which the committee will hold in cities throughout the country during the coming year. The hearings are to form the basis for legislation to be proposed in the general area of the problems of the aged and the aging, and which may be introduced and considered in the Second Session of this Congress.

At the request of the House Committee on Ways and Means during hearings on the Forand bill last year, the Secretary of Health, Education and Welfare has submitted a 117-page study on alternate ways of insuring the cost of hospital and nursing home care of OASDI beneficiaries. In the introduction the study gives reasons why the Federal Government should and should not take action in this field.

In support of instituting a Government program, however, the report presents five arguments. They are: The Government can better and more equitably distribute the cost burden for such a program than can private industry; voluntary health insurance would be relieved of the responsibility for insuring the older aged; the older aged would receive more extensive and more adequate protection than is presently available; the spreading of costs to the entire population would result in less cost to the individual during his working years; and overall costs of the program would be lower due to the size of the group involved, and the utilization of existing systems of collection.

In his letter of transmittal, Secretary Flemming concluded by saying: "Having completed this compilation, we are proceeding with an analysis of the policy issues involved with a view to developing specific recommendations."

A significant paragraph in the introduction to the study states: "In our society the existence of a problem does not necessarily indicate that action by the Federal Government is desirable. The basic question is should the Federal Government at this time undertake a new program to help pay the costs of hospital or medical care for the aged, or should it wait and see how effectively private health insurance might be expanded to provide the needed provision for older persons?"

I have reviewed for you briefly some of the steps insurance companies will be taking to expand its facility but the real problem today is the *cost* of health. This must be faced squarely as it is not the sort of a problem which will just disappear. Some day, somehow, somebody or something is going to impose limitations on that cost. How much better it is when medicine takes the lead and makes its deal with the public as to what that cost should be. In a number of instances local medical societies are leading the way to complete elimination of grounds for criticism of doctors' fees by a dollar conversion factor applicable to relative value schedules. In other words, they are announcing to the public the price of every service irrespective of to whom rendered or by whom paid.

Through this avenue they remove the mystery of the cost of health and at the same time preserve the very tenets on which the practice of medicine is based.

It has been ably stated that all legitimate voluntary approaches to financing health care costs are equally entitled to the enthusiastic support and cooperation of medicine. Medicine has recognized

that voluntary health insurance is the sound and practical device for financing health care costs within the structure of private enterprise. We look forward to sharing with you the joint responsibility for its successful operation.

To strengthen our ability to work together and this should be an integrated and cooperative effort at the community and state as well as at the national level, state insurance committees have been organized under the guidance of the Health Insurance Council in almost every state. In New Jersey, that committee is under the chairmanship of Mr. Ardell T. Everett of the Prudential Insurance Company of America. Mr. Everett and his associates stand ready to provide information and technical and practical counsel regarding health insurance coverages to all groups concerned with health services. The future actions of insuring organizations and of the providers of hospital and medical care will greatly influence the outcome of today's problems. Cooperatively medicine, hospitals and insurers can demonstrate that the voluntary system can attain the goal of better health for the American people.

THE MODERATOR: Thank you very much, Mr. Neal.

We have heard now from a dispenser of medical care, an underwriter, and I have by my own volition characterized our next speaker as a recipient or at least one who does want to receive for himself, his family and his public in general good medical care. Mr. Walter L. Kidde, Treasurer of Walter Kidde and Company and Walter Kidde Constructors, a former Chairman of the State Commission to Study Administration of Welfare.

(Applause)

MR. KIDDE: When I accepted the assignment to take part in this discussion, I did so in the hope that I might be able to make a contribution by way of suggesting some constructive action. I thoroughly share your abhorrence for the threat of socialized medicine and the many steps leading in that direction that are being persistently advocated in various quarters. I believe, however, that some of these proposals have such terrific emotional appeal that they cannot be defeated unless constructive alternative programs are widely and well sponsored.

The analysis of popular need and demand is an important first step, because sooner or later popular demand to satisfy unmet popular needs will translate itself into law. We should, therefore, examine the need and try to inject as much intelligence as possible into the demand. Popular demand will follow such leadership as makes most sense to most people. It will be guided by self-interest and wishful thinking, unless the fallacy of such paths is aptly demonstrated.

On the subject of medical care, you doctors are in the best position of all to influence people's thinking. Your position, backed up by intelligent reasoning, can be a foremost factor in arriving at a sound program.

In the past few weeks I have spent considerable time thinking about and discussing the problems involved, and the more I have done so, the more I have come to realize the extremely complex nature of the subject we are dealing with.

One of the principal factors that makes the subject so complex is the extent to which the failure to provide against abuses and opportunistic conspiracies can defeat even plans based on the most soundly conceived methods and objectives. I think my friends in the insurance industry would agree with that view.

It is bound to be important, therefore, that better methods of policing be incorporated into whatever programs are developed. The origin of voluntary pre-payment medical plans came from associations of closely-knit groups, where policing of the ethics of the members and their physicians was virtually unnecessary, being automatic. However, when this type of plan was introduced to the general public, failure to provide adequate policing safeguards caused rates to rise almost from the start. Unfortunately, the extent of this rise was considerably masked by the similar effect of rapidly increasing levels of medical costs. It is probably impossible to evaluate between the two factors, but I am convinced that each is substantial. In a recent address to the Essex County Medical Society, the Executive Vice-President of New Jersey's Blue Cross Plan recognized this situation and called most appropriately and, to my mind, necessarily, on the medical profession to lead the way in correcting abuses under the present plan.

I note with great satisfaction that the medical staffs on some hospitals have been making a start in finding an effective method of policing. I realize how much it is anathema to the high-minded and devoted type of physician to feel that he should be asked to sit in judgment on other members of his profession. Unfortunately, I see no present alternative, unless all the voluntary insurance carriers and governmental units collaborate in an expensive system of investigation. Even this, however, might not work so effectively.

My first recommendation for action, therefore, is the establishment of effective methods of policing the use of hospital facilities.

Next, I would like to propose a change with respect to voluntary pre-payment plans. There is a continual tendency on the part of the Blue Plans in New Jersey to expand services on a universal basis with, I fear, too little consideration for actuarially sound methods of financing. For instance, there is coverage for retirees over 65 at the same premium rate as now charged to other non-group subscribers. This, in spite of the known fact that this coverage is at least twice as expensive as the coverage afforded to those of lower ages. Under the smeared cost system of the Blue plans, such a feature places the burden of the excess cost principally on those who pay the premiums for group coverage. Along with this and other proposed extensions of service care will have to come continuous and substantial increases in cost, which run the risk of pricing this method of voluntary pre-payment out of reach of large segments of the population, both industrial and

individual. As noted by the Study Committee appointed by the State Commissioner of Banking and Insurance, this could lead to a situation where the Government would be forced to step in and pull the chestnuts out of the fire. In that event, socialized medicine is closer than we may realize.

There is another paralleling development which I believe to be utterly demoralizing to our society and economy. I am of the opinion that the trend to non-contributory group insurance has gone much too far for our economic and social good. Due both to the abuses which grow up under it and to the public attitude which it fosters, we are creating a degree of irresponsibility in people which is rapidly promoting the welfare state. People are coming to expect all of their medical care to be provided free. I believe we should move as rapidly as possible in the direction of restoring a greater degree of personal responsibility. If it is too late to return to the contributory principle on a percentage of pre-payment basis, then personal responsibility should be re-injected through the operation of deductibles and co-insurance features. I believe these could be sold to the public if sufficient added benefits were offered, and the trade I have in mind is the type of benefit offered under the so-called Calamity or Major Medical coverage. Such coverage is real insurance anyway as contrasted to short term coverage which is really merely a form of budgeting. Even a $25 deductible clause would constitute a tremendous saving to insurance carriers through the elimination of a very considerable administrative cost, and through its effect in stimulating more efficient methods of care in non-emergent illnesses, because the insured would be bearing all or part of the cost. The return to a program including co-insurance features, which could be greatly stimulated if the physicians of the country strongly endorsed it, would be the biggest single factor possible in keeping medical care costs under reasonable control, and this, I believe, without sacrifice in the level of care. Again in this connection, however, for optimum results, responsibility and discipline must be achieved, on the part of the medical fraternity as well as the insured. Under any insurance plan, individual greed and opportunism can frustrate any method, however sound, if not kept under reasonably rigid controls. In this case, control can only be accomplished through the cooperative efforts of the medical profession and the insurance carriers.

My second recommendation for action, therefore, is to sponsor the type of policy that provides a deductible area and a co-insurance feature, and to insist on coverages that are actuarially sound for broad, but not all-inclusive, classes of risks.

Finally, I would like to come back to the problem of finding a sound alternative to the Forand type of proposal with regard to the aged. My solution to this is based on facing what I believe to be certain present facts and conditions. It is probably true that a large percentage of the aged cannot afford necessary medical care on either an actuarially sound pre-payment basis or on a post-payment basis. They are at the end of the productive trail, victims perhaps of their own irresponsibility in the past, but nevertheless they are where they are. And our society today has pretty thoroughly adopted the principle that no one in need should go without care. In other words, they must be helped. My answer to their need is the same as that for another very large group of people who are economically competent to get along satisfactorily until illness strikes, but who find the costs of major illness beyond their means. I reject the idea that the cost of this care without regard for need should be foisted on those who are paying for and building their own health security. To provide for the needs of those who cannot defray their own medical costs, I propose again the solution to which our Commission studying the administration of welfare in New Jersey arrived several years ago; that is, that a new category of public assistance be established for the so-called medically indigent.

Under this proposal, anyone claiming inability to pay hospital bills would file an application for assistance which would be referred to the County Welfare Board, who would investigate need and determine eligibility. Eligibility would be on the basis of slightly higher standards than are presently necessary to qualify for other forms of public assistance, but an agreement to reimburse would be incorporated in the application. The Welfare Board would, however, have discretion in seeking recoveries to avoid future sub-standard living conditions. This would apply particularly with respect to the aged. The establishment of this category would assure that no one in need of hospitalization would be unable to obtain it, just as in New Jersey today it can fairly be said that there are none in real need of food and shelter who cannot obtain it.

A corollary benefit of the plan would be an improvement in financing hospital care for the indigent. It is proposed that in the case of all recipients of public assistance, payment can be made by the assistance agency direct to the hospital on the basis of patient-day costs. Such costs would be determined on the basis of a reimbursible cost formula developed under the supervision of a Commission on Hospital Costs, set up within the State Department of Institutions and Agencies. Provision would be made for a level of payment to any hospital which did not care to cooperate in such a determination of costs. It is recognized that this would create a higher level of payments than is now the case in many instances where per diem charges have been negotiated between hospitals and public authorities. However, there will be two major offsets to this increase—(1) in many cases, direct subsidies from counties or municipalities unrelated to patient day costs are making up the deficits—these would be eliminated; (2) the institution of a State-wide system of seeking recoveries from recipients who have been restored to an adequate income should produce a far greater total of recovery than is currently the case. It is not unlikely that such recovery may reduce rather than increase the net total of public funds paid for hospital care. In addition, I believe that such a new principle will benefit the hospitals and make it possible for them to finance their entire budgets along much sounder lines. If so, benefits should accrue to private patients who are currently bearing an unduly onerous burden, some-

times in two ways—through excessive charges for hospital care and through contributions to community chests which are already, in many cases, staggering under the loads placed on them by the hospitals.

My third recommendation for action, therefore, as a specific alternative to the Forand type of proposal, is to create a new public assistance category for the medically indigent, whether over or under 65, so that none who need hospital care will be deprived of it.

The MODERATOR: Thank you, Mr. Kidde.

We never can get away from taxes, apparently, and we are now coming down to that. Our fourth representative in the discussion of this problem and our speaker is Mr. Carlton W. Tillinghast, Executive Director of the New Jersey Taxpayers Association. (Applause)

MR. TILLINGHAST: Mr. Chairman and Ladies and Gentlemen of The Medical Society of New Jersey: Your Chairman has mentioned that we can never get away from taxes, and I'm reminded of the old saw that nothing is certain in this life except death and taxes. But one wit has made the very sage remark that the trouble is, they do not come in that order.

As has been stated from this platform, one of the perennial concerns of your profession is the various proposals which from time to time come before Congress and state legislatures across the country, to extend medical and surgical care in such a way as to threaten the free enterprise system as represented by the practice of medicine. I have made no detailed study of these proposals, nor is my purpose today to discuss them, except to point out one very obvious fact; that is, in some way or other all of them involve the cost of government; hence they all involve taxation in some form or other.

My contribution to today's discussion is to portray in rather broad strokes the background of governmental finance and taxation against which these proposals fall. Such a description should facilitate a broader understanding of the implications of the proposals than can be obtained through study limited to their purely professional aspects.

In my remarks I shall make use of some figures. This is unavoidable. I do not propose, however, to introduce a mass of fiscal detail. Nor do I even suggest that you attempt to remember the individual figures that I shall present. Instead, it is my hope to present them in such a way that they will leave in your minds a picture of some of the basic facts and trends with which all of us must reckon today, not only with respect to the expansion of governmental health and welfare services but of any of the services of government.

For the calendar year 1958, New Jersey taxpayers paid into the coffers of government more than four billion dollars in taxes. About 75 per cent of this went to the Federal Government, 18 per cent to local government, and 7 per cent to the State. We should not conclude that even the latter figure is inconsequential, for it represented a tax income to the state of $355 million.

Let us look first at the state and local share of this huge tax burden. Less than a decade ago, state and local government in New Jersey was spending one-half billion dollars. In the brief span since 1950, this has doubled. Government in the Garden State today is a billion dollar business!

I will not trouble you with a whole series of figures to indicate the way the expenditures underlying this huge tax bill have grown in state and local government respectively. Instead, let me suggest that you picture in your minds a simple pencil line moving from the left side of a page, and inclining sharply upward as it moves toward the right. That upward trend is the trend of both state and local government finance in New Jersey. In neither field does it show any real sign of levelling off. Instead, as it moves ever onward and upward, it makes heavier and heavier demands upon the individual taxpayer and necessitates that he relate more and more closely in his own mind the services which he desires of government, and his ability or willingness to pay for them.

Why has the cost of government increased? I believe the reasons can be narrowed to about three. First, New Jersey itself has grown. Since 1950 its population has increased about 100,000 people per year. This is equivalent to the addition of a city of 8,000 people every month. However, this is merely a net figure after accounting for all additions and subtractions. It fails to reveal the costly effects of the ebb and flow of population within the state. For instance, the outward movement of population from urban centers has greatly intensified the problems of municipal finance, both in central cities and in the mushrooming suburbs. It must be recognized, of course, that as the number of people increases the economy of the state increases and tends to produce greater tax income. However, other things being equal, this population increase would nowhere near account for the doubling in governmental costs that has taken place since 1950. We must look to other causes.

A second, which is driving the cost of government upward, is inflation. You have seen the effects of this in your own purchases. In the same manner it has affected the cost of government everywhere, making it necessary to levy higher and higher taxes in order to provide the same services once supplied for considerably less money.

Yet a third force is at work, drawing still further upon the taxpayers' pocketbook; namely, the extension and expansion of governmental services. Here we face the dangers of a vicious circle for, while inflation increases the cost of government, new programs of governmental service also add to the expenditures and when, as so often happens, particularly at the Federal level, these are financed through borrowing, the result is still greater inflation.

Government is not static. Practically nowhere is it performing just the same services in the same way as it did some years ago. Existing services are more elaborate. Entirely new services are added from time to time—all adding to the cost of government. Without belaboring the point further,

I think it is safe to assume that any major development in the scientific world will sooner or later have its impact on government and in some way offset the cost thereof. While we should recognize the increased efficiency and often lower unit costs obtainable through the use of modern inventions, their overall influence over a period of time has been to step up the quantity, quality and cost of the services of government throughout its three branches—executive, legislative and judicial.

But our concern today is not so much with the new and expanded services resulting from new technology, but with those occasioned by a changing philosophy. Year by year these have been reflected in greater tax bills as government has progressively assumed functions formerly the responsibility of individuals, and as the upper levels of government have assumed more and more of the functions once carried at lower levels.

Having stated these three reasons—population growth, inflation and expanding services—let us summarize their fiscal effect on operating expenditures of the various branches of local government. In 1953 the operating expenditures of New Jersey municipalities totaled $230 million. In 1958 they were budgeted at $330 million. School districts in 1953-54 spent $215 million. Currently their operating budgets total nearly $400 million. In 1953, New Jersey's 21 counties spent about $100 million. Budgeted for this purpose in 1958 was $150 million.

In the face of these local expenditures, there has been insistent demand that the state assume more and more of the burden of local operations. This has happened, and to a very marked degree. The 1960 budget presented by the Governor in February totaled $403 million, of which $176 million was in the form of state aid. Thus, state aid in the budget now under consideration is actually greater than the overall state budget as recently as 1950, when the total budget was $168 million.

Then why not, some people ask, turn to the national treasury? This course, too, has been pursued—again to a marked degree. Today the nation's programs of federal aid total more than seven billion dollars, contrasted to about two billion as recently as 1950. Various of these programs of aid to the lower units of government are in the social welfare and health fields.

According to the latest estimates every time the Federal Government spends $100 on one of these programs, New Jersey taxpayers provide $4.20 of it. For New Jersey this is no bargain, for by actual calculation a dollar of federal aid coming into New Jersey costs our taxpayers an average of $2.73.

We are oftentimes prone to set aside the problem of the federal budget, assuming that it is driven so high because of the necessities of national defense, and therefore that nothing can be done about it. It comes as a surprise to many people that in 1952 the Federal Government budgeted $47 billion for national defense, whereas in the budget now under consideration this had risen only to $48 billion, while in the same period the domestic-civilian budget (in which health and welfare programs appear) increased from $19 to $29 billion. Thus it is primarily the new and expanded federal services, many in the health and welfare categories, that are driving the federal expenditures upward and not defense, the expenditures for which are much more stable.

Those who would expand even more the Federal Government's participation in the domestic-civilian area should remember that in 24 of the past 29 years since the bottom of the depression, the Federal Government has spent beyond its income. When this happens the difference must be made up by borrowing. As a result the federal debt now stands at the all-time high of $285 billion. Year after year the debt has increased. If we cannot begin repayment now, in a period of record prosperity, thoughtful people ask, when can we?

If additional programs in the health and welfare field, or in any other field, are added to the federal budget without accompanying increase in the tax income, the cost must be translated into debt. This will push the economy higher into the stratosphere of inflation and drag the nation further toward the brink of bankruptcy.

My remarks thus far may seem to be somewhat distant from the subject of this panel. Now I think we must return. I have presented data to indicate that governmental finances are strained at every level. Under the impact of higher and higher taxes, taxpayers everywhere are becoming more restive. The recent imposition of additional taxes at the state level must be viewed in the light of its effect on the attractiveness of New Jersey as an area in which to carry on profitable business enterprise. To the extent that taxation makes the state less attractive, it will have a negative effect on the creation of job opportunities, and hence on the general welfare. Any diminution in this attractiveness will mean the loss of job opportunities and hence can bring increased demand on government for health and welfare services. At the same time, it will provide a weakened tax base from which to pay for them.

Clearly, the time has come when we must relate the demand for services to the ability and willingness to pay for them. Thus we are confronted not only with problems of governmental finance but with questions of basic philosophy. We must ask ourselves not only whether a service is needed but whether it is necessary that government perform it. Here we enter controversial areas because there are those among us today who work unremittingly for the transfer of individual responsibility to government, and for the centralization of governmental authority at its highest level. If we would have government provide all of the services and meet all human wants, then we must be prepared to meet the concomitant of this service, which is that we dedicate our income to government.

On the other hand, if we feel that this is not a desirable course, then I think there are a few simple rules that we can use as guides in appraising the proposals now current to extend and increase health and welfare services performed by the government.

First, I believe that we should require that the individual meet his own responsibilities when he has the capacity to do so.

Second, that his immediate family share this responsibility when necessary.

Next, that when payments are made on behalf of the individual, there should be an implied contract to repay to the extent of the recipient's ability when his restored economic condition so permits, short of returning him to a condition of indigence.

Finally, I believe there should be constant effort to direct governmental responsibility for individual welfare toward the lower levels of government, rather than toward centralizing it at the upper levels.

These rules are consistent with the principles of personal responsibility upon which this government was founded, and under which it has become great. They are the very antithesis of those principles which would relieve the individual of his responsibilities and which would concentrate at the upper level of government the care and direction of the individual and require more and more of the fruit of his labors in order to support the resulting gigantic structure of bureaucracy necessary for this purpose.

The reward for their observance will be the continued greatness of America as a land of opportunity.

The penalty for their violation will be the loss of individual liberty, in which the medical profession could well be among the first to suffer.

THE MODERATOR: Thank you, Mr. Tillinghast.

Now, we are going to have, if you wish, a period of questions and answers. Pass the queries towards the center aisle.

Please address them to a specific member of the panel. If not, I'll try to see that they get to the right answerer.

I have first a question for Mr. Kidde. Do you think that the unions would ever accept the deductible or co-insurance principles? Is this not the significant approach to the problem?

MR. KIDDE: The obvious answer is that the unions won't accept them knowingly. But that does not necessarily make it impossible to move in that direction. In the first place, as the costs of particularly the Blue Plan insurance continue to mount, this becomes a matter where the unions will have to realize that it is taking its place at the bargaining table and cutting into direct salary. If it goes too high, management has got to balk at paying the bill. This gets right into the field of negotiation at that point; and perhaps it is possible to make the unions realize that to keep the cost of adequate medical care reasonable it's going to be necessary to have some control or policing of the situation that is soaring beyond the bounds of reasonable practice.

It is possible that we could gradually come to a system of deductibles at least a co-insurance basis but it isn't going to come overnight. It is something that is going to be worked towards gradually and as hard as possible from as many influences as possible, and I think that the medical fraternity is in a very good position to sponsor such a move.

THE MODERATOR: Mr. Neal, a member says that you emphasized the M.D.'s fee as the hazard of sickness insurance plans. Is it not true that hospital costs are the greater burden and fully as inflated, even more so, than the M.D.'s fee?

Are all insurance companies willing to accept the 65-year-old and over applicant in an eligible income level in a non-profit plan?

MR. NEAL: Certainly the more flexible item in the cost of care is the physician's fee. You fellows have been taking care of the over-aged people for a long, long time for nothing and getting no credit for it. And if he is hospitalized, he's got fixed costs which in that case are certainly the prime part of the cost in his health care. But you have, in addition to control of your fee, control over the utilization factor of hospitalization, so to that extent really I think that the solution or at least a good part of it rests in your hands.

THE MODERATOR: Are all insurance companies willing to accept the 65-year-old and over applicant in an eligible income level in a non-profit plan?

MR. NEAL: I don't believe I understand the question.

DR. JOHNSON (Trenton): The question is this: Is there a mechanism whereby insurance companies could participate in helping the 65 and over by accepting that group in the $2,000 or whatever level is set and carry those subscribers on a non-profit basis even though they may be a profit-making organization?

MR. NEAL: Let's put it this way: A mutual insurance company is about as much a non-profit organization as you can find, and they, to the extent that they will carry them, have probably already answered your question. An insurance company is not writing on a service basis; it's writing on the dollar end of the program.

THE MODERATOR: This one is addressed to Dr. Schaaf: Since we are living in an era of hormones and vitamins, the age at which a person should be retired should be changed to 70 instead of 65. It seems illogical to retire people just when they are raring to go.

DR. SCHAAF: The compulsory retirement age of 65 is a totally uneconomic feature of our present social life. Compulsory retirement was initiated some time in the mid-thirties and it was a depression measure designed to free the labor market from the older workers and make room for the younger ones. At the same

time, the age at which people would go to work was raised from 16 to 18. In other words, you narrowed the area in which people could work.

Now, what has happened is that with the increased life span on the average of 70 now, we have a great many people who are, in increasing numbers past 65, who will become a burden on the economy because they are not supporting themselves by their own efforts. And my own answer to this question is that if it must be a compulsory retirement age it should be 70 instead of 65. I think the whole economy would be better off if more people kept working longer.

THE MODERATOR: Mr. Kidde, will industry support a higher negotiation for health and welfare benefits for retired workers rather than the Forand approach?

MR. KIDDE: Industry is not a single unit, obviously; and some businesses will go a lot further in that direction than others will. The trend is gradually towards a more continuous system of coverage. Some companies are already giving their retirees health insurance coverage.

Frankly, I don't know that I'd like to see that answer go too far because I don't think it is the right one. The better answer is to inculcate a degree of responsibility on the part of people which will gradually get them to provide more for their later years, whether it be through negotiation of company benefits or whether it be through their own savings, but at least to the point where they take some responsibility in that respect. There will always be the hardship cases and the cases where people's savings are lost or something like that. In those cases we will always have to have some form of public assistance to help people who otherwise would be in severe need. But, as close as I can come to a specific answer, the trend is in that direction.

THE MODERATOR: Mr. Tillinghast, I'm not ignoring you at all, but apparently these people are staying away from the tax end. Here is another one —for Dr. Schaaf.

Do you feel hospitals could practice economies to reduce their part of the cost of hospital treatment?

DR. SCHAAF: To be sure, some hospitals are operated more economically than others; but by and large much of the hospital expense is due to the requirement that all facilities be available and staffed at all times. It's like a fire department which you keep. You hope you are never going to have a fire, but you keep your fire department going. Now, you've got to have all of the modern diagnostic areas properly covered in hospitals. This means technicians, it means doctors, it means nurses, it means dieticians. It means everything. Now, you might not use a particular transfusion service once a month or once in two months, but it still has got to be there.

The greatest part of the increased costs of hospitalization is the result of labor. It may not be the labor in the hospital itself which has gone up, but everything which is manufactured has a greatly increased manufacturing cost. And it's improper to say that at least 90 per cent of the rise in hospital cost is due to rise in labor cost because even the food is prepared and brought in and all the instruments and equipment that you buy have an increased labor charge reflected in them as compared to five or ten years ago.

There are areas in which there is some extravagance, but by and large any qualified hospital administrator tries to keep his costs down. Some hospitals are operated on a more luxurious scale than others—larger rooms, rest rooms, recreation areas, sun porches and so on. They are all costly, and once it's built it doesn't cost too much more to maintain it. I think in general it's due to the rising cost of labor in all fields.

THE MODERATOR: Mr. Neal, someone asks this. Your implication is that unnecessary hospitalization is the responsibility of the doctor. But, the abuse of hospital facilities by subscribers is stopped more often in the doctor's office. Why do insurance policies put in small print the non-covered services? Why not educate the subscriber more than is done?

MR. NEAL: First I want to dis-abuse your minds that there is such a thing as small print in insurance policies. It may sound funny to you, but actually that is all governed by statute.

A better answer, I think, to the question is that under the comprehensive coverage where you've got a deductible and co-insurance that you begin getting an education across to the fellow that's going to have to pay the first $50 and 20 cents out of every dollar that is spent after that. And perhaps you will get a better understanding on the part of the patient wanting to go to the hospital for a rest, for example.

THE MODERATOR: Mr. Neal; another for you. You predicted the pre-payment plans will increase for the next ten years. Was not the same prediction made three years ago in Canada and have not pre-payment plans in Canada now been practically wiped out? What makes you so sure it won't happen here?

MR. NEAL: Well, you've got a different situation legally in this country than you have in Canada. Number 1, you can't wipe out by legislation all the contracts that are presently

in force, as they have done there. I don't recall the prediction having been made in Canada, but I can certainly base a prediction I made for this country upon the rather dramatic increase that has taken place over the last ten and, even more, over the last five years; and when the demand becomes so apparent to find a way of prepaying for health services, as has been evidenced in the past five years, it's going to go on. In Canada there is no such thing as a pre-payment program for the basic hospital coverage anymore. It's all been taken over by the government. The next question is: Can we prevent that from spilling over to the medical services? And the next question is: Can we keep it north of the border?

THE MODERATOR: A member asks: Is there any conflict between the suggestions for an increase in co-insurance plans and the concept of Blue Shield plans? Dr. Schaaf.

DR. SCHAAF: The basic philosophy underlying the Blue Shield Plan was one of service benefits for people whose incomes were below a certain level. We fear that a deductible feature will defeat the purpose of the plan. It would actually put it upon an indemnity rather than a service benefit basis. If we were to go on an indemnity basis it would be very much better for Blue Shield; that is, for doctors to vacate the field of prepaid sickness insurance because the good commercial insurance companies on an indemnity basis could do a much better job than we can. They can do it more efficiently. I don't like to admit that, but that's true, and there is no excuse for doctors being in the insurance business except they administer a service benefit program.

THE MODERATOR: The last question as of now, and possibly a loaded one: The abuses of medical care. Please discuss briefly those abuses in the hospital and out of the hospital. Who do you think should discuss that? Abuses of medical care inside and outside of hospital.

DR. SCHAAF: There has unquestionably been an abuse of hospitalization, not only Blue Cross but also the commercial insurance companies. The abuse of the commercial companies is not quite as great as it is with Blue Cross because the commercial insurance companies in many instances have a deductible feature and in any case it's on an indemnity basis, whereas the Blue Cross is on a full coverage service benefit basis, although the contracts very specifically state that certain services are ineligible for payment, particularly diagnostic x-ray service, electrocardiography and a few other things, and that no hospitalization is eligible if the admission is primarily for diagnosis.

Now, as I said previously, I think with all honesty—I'm not criticizing the doctors—as I've heard said many times in the House of Delegates, the doctor thinks that that particular service is in the premium rate. I've heard him say that. You can't disabuse their minds of the fact that it is *not* in the premium rate, that it is definitely excluded. They honestly believe it's there. The patient paid for it; he is entitled to have it. And it's a matter of human psychology that if we pay it, if we think we paid for something, we want to get what we can out of it.

And there is unqestionably over-use (not abuse) over-use of hospitals which is innocently brought about by doctors. They honestly think that the service is covered; the patient is entitled to it; he ought to have it. When you use the term "abuse," you then have an intentional over-use, which is a little different. I don't think there is so much of that.

THE MODERATOR: Would you care to comment, Mr. Kidde, on this particular question?

MR. KIDDE: What Dr. Schaaf said is true of probably the greatest number of physicians. I would, however, feel that there are exceptions. I think that the employees generally or others who are financing their own pre-payment plan expense either don't read their policies too carefully, or if they do, they have the feeling that if they can get away with it, they would like to. They go to the hospital for nothing. If they get medical treatment at home, it's going to cost them something; consequently, they want to go to the hospital. I think there are even cases of conspiracy between the patient and the doctor, where a patient gets the doctor's help in getting into the hospital because he feels that that is going to save him money, and the doctor goes along. So much for that one type of abuse.

The other type of abuse is so prevalent that Mr. Durgom in his speech to the Essex County Society a little while ago practically wrote off major medical coverage as being impractical because it was subject to such abuse and the abuse there is obviously the amount of the fees.

I don't think that in saying "abuse" I'm trying to castigate people as being wicked or anything like that. It's perfectly normal and perhaps human nature to try to get what you can. And, of course, what the traffic will bear has always been a certain part of the way in which medical fees have been based and perhaps reasonably so; but if the profession realizes the dangers that are inherent in this abuse, perhaps a control can be brought into the situation which will salvage and make possible

the best plan that the insurance industry has devised yet. Major medical coverage is real insurance. It's insurance against calamity. It's what society needs to prevent people from getting into trouble and breaking down economically on long-term illnesses and so forth. It's that kind of coverage that is important. The other, this short term stuff, is just budgeting. When you get right down to it, you are virtually budgeting your own health costs if you are an average family and you are paying for it or you are getting your employer to pay for it in advance or currently instead of having to pay it when the bill comes in.

THE MODERATOR: "Major medical" has been characterized as one of the greatest compliments that has ever been paid the doctor as an individual. Do you feel that it offers a way for violation, too?

MR. KIDDE: I don't think it should and I think it is a very important form of insurance that we should do everything to protect; but if it has gotten to the point where Mr. Durgom can practically write if off and say it is impractical, it's obvious that there must be some serious abuses entering into it because he wouldn't say that.

THE MODERATOR: Mr. Neal, did you wish to comment?

MR. NEAL: We rely on enlightened self-interest of the medical profession to prevent just that from happening. The word "abuse" reminds me of one other item that I'd like to invite attention to—the so-called "abuse" which is the greatly inflated bill for a small service rendered—a $1000 bill for a broken wrist, something of that kind. That is an abuse that is easily handled. You have your grievance committees, people like that we can come and talk to.

I don't like to categorize it as an abuse, but the real difficulty here is the more subtle tendency to increase the cost of service by ten or fifteen per cent simply because there is insurance involved to pay for it. When you get that done as a mass across the board, you raise the whole cost of medical service by that ten or fifteen per cent. Then you've got a real problem on your hands. It's one that is much more difficult to cope with and one which really comes through education throughout the medical profession. Otherwise, I don't think I've seen too much in the way of abuses that I want to comment on.

THE MODERATOR: Well, thank you sir. I wish I were so well informed that I could add something to this presentation, but I know you will be grateful to me that I am not.

On behalf of Dr. Bowers and Dr. Gardner and the whole Medical Society, I would like to thank these four men for their fine contribution to our annual convention.

This will conclude our program for this afternoon.

(The meeting was concluded at 5:20 p.m.)

Speakers' Section of the Banquet

Tuesday Evening Session, April 28, 1959

The speakers' section of the banquet program convened at 8:45 p.m., Dr. David B. Allman, Toastmaster.

THE TOASTMASTER: Honored Guests, Fellow Members of The Medical Society of New Jersey, Visiting Firemen, Friends: This is the 193rd annual meeting of The Medical Society of New Jersey, and as you probably all know this dinner-dance is given in honor of our President and Mrs. Kenneth E. Gardner under the auspices of the Woman's Auxiliary to The Medical Society of New Jersey, to whom we are indebted for such a fine evening.

I want to welcome you in behalf of the Medical Society of Atlantic County, although our President is here; he can speak for himself. I want to welcome you in behalf of the city and in behalf of the hotel. We are sorry you got such miserable weather today, but that's coming down from North Jersey.

Before I start, some people said to me: "Dave, why do you want to be Toastmaster? Why do you want to waste your time?" Well, if you look to my immediate left and my immediate right you will see the answer. Anybody would be crazy if he didn't take this seat.

I'm down on the program as Toastmaster.

I firmly believe in the old saying that if all toastmasters were laid end to end it would be a good thing. I'm thoroughly in accord with that. I've also found out as I traveled around that it doesn't always pay to talk. Sometimes it's better not to talk.

I'm always reminded of the very valuable parrot that my friend Ralph Buchanan gave a bookie. He owed him a little money and Ralph had to give this bookie his parrot. It spoke three languages, German, French and English. The bookie carried him around with him. One day the bookie goes into the bar with this parrot and got in conversation with the bartender about the parrot. The bookie says, "Oh, yes, the parrot can speak three languages." The bartender looked at him. He says, "I mean it." The bartender says, "Oh you're crazy." The bookie says, "I'll bet you $50 even he can speak three languages." So the bartender pulled out his $50, the bookie pulled out his $50 and gave it to a third party. Then the bookie turned to the parrot and said, "Parley vous Francais?" The parrot just looked at him. "Sprechense Deutch"? The parrot just looked at him again. The bookie says, "Come on, Polly, say something in English." Polly never opened his mouth. So the bookie hands over the $50 to the bartender and walks out of the saloon very disgruntled. Outside he starts giving the parrot the dickens. "Why didn't you talk, you dumb so and so? You know you can speak three languages. Why didn't you talk?" The parrot says, "Don't be so stupid. Think of the odds you'll get tomorrow when you go back there." (Laughter) So it doesn't always pay to talk at all times.

The official welcome will come from Mrs. A. Guy Campo, the immediate Past-President of the Woman's Auxiliary to The Medical Society of New Jersey. Now, while she officially went out this afternoon, as far as this affair is concerned she is still your President.

It gives me great pleasure to present Mrs. Campo. (Applause)

Mrs. A. Guy Campo: Dr. Allman, Dr. and Mrs. Gardner, distinguished guests, officers and members of the Medical Society and the Woman's Auxiliary, Ladies and Gentlemen: I am privileged in the name of the Woman's Auxiliary to invite you to this evening of fellowship and sharing in this happy experience in the lives of Dr. and Mrs. Kenneth E. Gardner; Dr. and Mrs. Gardner being honored together. For this we are very proud, happy and honored.

Those of us who have come to know Gladys as she traveled around New Jersey and other states with our man of the hour feel that she has contributed greatly to the success of her distinguished husband.

All of us who fell in love with and pledged our hearts and our lives to physician-husbands have dedicated ourselves to a lifetime of assisting and comforting those dedicated to assist and comfort others. Our communities all recognize this fact. They have a pattern in which each one of us as Mrs. Doctor is called upon to fit. Conscious of this, the programs of the Woman's Auxiliary are designed to help each one of us fulfill this expectation. To some extent it is rather sort of a charm school and educational forum so that the understanding and the cooperating member of the Woman's Auxiliary can better serve her husband and the medical profession and the community. Ours is a labor of love. We work hard and wholeheartedly to do our part well. We hope that you may be pleased. (Applause)

The Toastmaster: Thank you very much, Mrs. Campo.

Mrs. Campo says that Gladys has done much to make Ken Gardner's administration the great success that it was. As a matter of fact, after the first month in office we didn't refer to him as President Gardner anymore; we called him Gladys's husband. (Laughter)

It gives me great pleasure at this time to introduce a couple of people who will soon officially ascend to high office. And the first lady I would like to present is down on your program as President-elect of the Woman's Auxiliary, although she is really President, having assumed that office and been installed this afternoon. It gives me great pleasure to present Mrs. George O. Rowohlt, who is the President-elect of the Woman's Auxiliary to The Medical Society of New Jersey. (Applause) We certainly hope you have as successful an administration as your predecessor and as many of your other predecessors, and we feel sure that you will.

Now, it is my extreme pleasure to present the present incumbent to the presidency of The Medical Society of New Jersey, a man who most of us have known for many years, who has done indefatigable work for all of us in the various positions he has held in The Medical Society of New Jersey and he has now reached the zenith of the offices which we can confer upon him. We know that he will carry on in the same fine tradition as Ken Gardner has.

It gives me great pleasure to call upon and present to you your new President, Dr. F. Clyde Bowers. (Applause)

President Bowers: Thank you, Dr. Allman.

I'm very happy to have this opportunity afforded me by the Woman's Auxiliary to come here and participate in a well-deserved tribute to Dr. and Mrs. Gardner. Dr. Gardner has done a tremendous job for The Medical Society of New Jersey during the past year and I hope that I can do as well in the next year. He has tried desperately to steer me on the right course, and any success that I have I'm sure a great deal of it will be due to his management. By the same token, if I fail, Kenneth, you are going to be blamed. Thank you very much. (Applause)

THE TOASTMASTER: Thank you, Clyde. We are certain that you are not going to fail and we are sure that Ken Gardner will have to accept no blame for what you do.

The next portion of this program is the ofcial business part of the program, so to speak. It's one which we of The Medical Society of New Jersey look forward to with great pleasure. It is the presentation of the Fellow's key. This is presented each year at this time by the immediate Past-President to the incumbent of that office. And I'm sure that when I present to you Dr. Lewis Fritts, our immediate Past-President he will come here with a feeling of great pride to present to Dr. Gardner this Fellow's key because no one ever deserved it more. I'm sure that Dr. Fritts feels highly honored to be called upon to present this key to Dr. Gardner.

It gives me great pleasure to call upon Dr. Fritts to do so. (Applause)

DR. FRITTS: Mr. Toastmaster, Guests of Honor, Ladies and Gentlemen: It has been my experience that the ties of interest and service which bind one as President to the Society do not appreciably diminish with the end of one's term of office. There continues to be a strong bond, real but imperceptible, which links the heart of the man to the heart of the Society.

I know what is true for me has also proved true for all others who have held the presidency of The Medical Society of New Jersey.

So, Ken, it will prove true for you. You will find, as the wise old Queen Elizabeth once observed, that "old love is not easily forgotten;" nor should it ever be.

To externalize the bond between the ex-president and the Society he had the honor to serve, the category of the Fellows was created. It is my privilege and honor tonight, Ken, to welcome you into the select group of the Fellows and to present to you the Fellow's key as a token of your new status.

By your loyal and unselfish service to the Society as its President, you have well merited the affectionate gratitude and respect of all the members. I know that now they all join me in thanking you and in wishing you well.

May you continue to serve the Society and to influence it for good. May your years as a Fellow be many and happy. May this key, which I now give you, through the years serve to open to you the hearts of all your colleagues, and to lock your heart against all impacts other than those of genuine happiness and true delight.

(Standing ovation as the Fellow's key is presented to Dr. Gardner)

DR. GARDNER: Thank you all very much, and thank you, Lew.

I am most happy to receive this key from Dr. Fritts who is one of my oldest friends. Lew and I interned together, about 30 years ago at Philadelphia General Hospital, known to many of us as Old Blockley.

In accepting this key as a Fellow, I fully appreciate that I am joining a very distinguished group of physicians, all of whom have contributed much to our Society. To have served the Society as President has been an honor. It has been a privilege; it has been a distinction. It is a memory that I shall always cherish.

I should like to thank the Woman's Auxiliary for sponsoring this dinner tonight, for this dinner will always be a memorable occasion, I'm sure, for both Mrs. Gardner and myself. It really marks the end of a very rewarding experience for both of us. And in addition to having interned with Dr. Fritts at Philadelphia General, I also met Mrs. Gardner there. (Applause)

And now if I may take this opportunity, I'm going to ask Mrs. Gardner to join me here at the microphone. She doesn't know about this.

Gladys, it's been a long time since I've been in organized medicine and during all this time I have been away many days and many evenings and you have never complained. And so I'd like to give you a little gift in appreciation for your support all these years. To you, Dear. (Applause)

At this point this ends, should I say, the formal part of the program. As I came in tonight, I was given several sheets of paper and I find that there is a surprise part to this program of which I am a part. And so at this time I would like to ask: And who do we have here?

(Short entertainment program)

DR. GARDNER: Thank you very much. The following note says: This bit of nonsense was presented by the New Jersey Medical Sales Representatives Association, Incorporated. Puppeteers and marionetteers, Ted Taylor assited by Sam Spina, Adolph Schmidt and Joe Mayham. Thank you very much. (Applause)

There is just one other bit of recognition I would like to make tonight. A convention doesn't just happen, and there are several members here that I feel it is only fair to pay them just tribute. The first is the Chairman of our Annual Committee of the Convention, Dr. Jerome Kaufman. Jerry, take a bow, will you? (Applause)

One of our very hard working men in the whole Society, Dick Nevin. (Applause)

Over there in the far corner, the girls who really do the work and put the convention on, the unsung heroes of the convention—Mrs. Madden and our staff. Please stand up, girls. (Applause)

Thank you all very much.

THE TOASTMASTER: Thank you Ken. Thanks for taking some of the work off me. I was going to introduce the girls but I was going to say a lot more nice things than you said, I can tell you right now.

Ken has made us a great President, as most of the doctors know and as you ladies should know. You all know Ken comes from Bloomfield, got his bachelor of science degree in biology at Bucknell, got his M.D. degree from the University of Pennsylvania, works at Mountainside Hospital in Montclair, as you know, and he belongs to various medical societies, including the American College of Chest Physicians.

Ken, incidentally, as many of you may not know, is the illustrious Potentate of Salaam Temple, and if you think this is a tribute to Ken you should have been up to Paramus, New Jersey, about a month ago when they put on a ceremonial for Ken. And Gladys and I want to tell you it was a terrific deal.

And because Ken is such a big man, even though the key he received means more to him probably than any other gift he has ever received, because I got one last year and I know it means more than any I received, it's such a small token for a big man that the Mayor of Atlantic City thought I should give him a man-sized key. And, Ken, it gives me great pleasure to present to you, in behalf of the City of Atlantic City, a real key. (Applause) This key, of course, will get you into lots of places that you should not get into. (Laughter)

Inasmuch as you are Illustrious Potentate of Salaam Temple and inasmuch as the National Shriners are going to meet here in July, knowing you as I do I'm sure you are going to get in trouble with or without the key. And so that you can get out of that trouble when you get into it, it gives me great pleasure, in behalf of the Mayor and the Commissioners of Atlantic City, to present you with Special Detective Badge Number A-51, which I hope you will use with discretion. (Applause)

Now, there are many important people in this room. I can't commence to present them all. I want to present to you first those at the head table from whom you have not heard and from whom you will not hear officially.

The first is Mrs. Campo's husband, Dr. Campo. (Applause)

The second is Mrs. Lewis C. Fritts, the wife of our immediate Past-President. (Applause)

The next, as you know, is my wife whom you have seen and heard for many, many years. (Applause)

You have just seen Gladys, but I want to present her again because she seriously has been so helpful to Ken in everything he has done for many, many years and particularly during the past year she has truly been a wonderful First Lady of Medicine in New Jersey, and we all are deeply indebted to Gladys. (Applause)

The lady on my immediate right happens to be the wife of the President-elect of the American Medical Association, who for the next fourteen or sixteen months will be a widow. In June 1960 she will get her husband back, but until then she will be alone lots of time. I want to tell her right now in public that if she ever feels too lonesome—I'm out of a job, Mrs. Orr. (Applause)

The next lady is also going to be a widow for the next year because she happens to be the wife of our new President—Mrs. Bowers. (Applause)

The gentleman on the end is going to be a widower because today his wife assumed the presidency of the Woman's Auxiliary to The Medical Society of New Jersey—Dr. Rowohlt. (Applause)

And then there is a very dear friend of mine and a friend of yours in the audience here, whom I'd like to stand up to take a bow, and that's Mrs. Albert Kump. (Applause)

Now, as I say, there are many others of you who deserve recognition, but the hour is getting late and we still have some entertainment for you and we have some words of wisdom for you, so to all of you other grand

people whom I have not introduced, please forgive me. It's not because you are not as important as those that have been introduced.

The next thing on the program—the next item on the program, I should say, is down as Guest Speaker. The gentlemen is a guest, a most distinguished guest. The gentleman is a speaker, the most eloquent speaker. But he is not here tonight as a guest speaker. This is Ken and Gladys's night. We are not going to have any guest speakers or any toastmaster or anybody else to detract from them. But we are greatly honored tonight in having with us the President-elect of the American Medical Association. We in New Jersey very seldom have anybody high in the office of the American Medical Association, and it's a great honor and a great privilege for us to have Louis Orr here in his official capacity as President-elect of the American Medical Association.

(Standing ovation)

Dr. Louis M. Orr: Mr. Toastmaster. Mr. Honorary Mayor: The other day I saw this program and I saw that it had down "Guest Speaker." And, of course, I rang Dr. Allman on the 'phone and I said, "Dave, what is this all about?" He says, "I don't know. You got yourself into it; get yourself out of it."

It puts me in mind of a situation that arose when a married woman had to make a date at a bridge luncheon. It was up the street, in the upper forties and she had to be there and she was shy a girdle which she had ordered. She called the department store, in great distress, and said, "I've got to have my girdle." The sales lady said, "I'm sorry madam. your girdle hasn't come in." She said, "Well, send me something. Send me something quickly. I only have a few minutes." The girl called back later to say the girdle was on the way but it's going to be a little oversize. She said, "That doesn't make any difference. Get the girdle out here as quickly as you can."

She put the girdle on. It began to itch a little bit. She put her dress on, got everything fixed up pretty good except for this itching.

Well, she went over, was prompt in the receiving line, and she remembered in this home there was a recreation room downstairs and she thought right away well, there will be a little piece of drapery that I can steal and I'll put it down in here and I'll take care of this little irritation.

She slipped away a few moments later and went down to the recreation room, and lo and behold, the draperies had all been taken down. There was a billiard table and all the chairs, but she couldn't find a single bit of loose cloth or material of that sort at all. The only thing she saw was a pile of comic books on the billiard table. Well, in desperation she reached out and took the first comic book, tore out seven or eight pages and stuffed them inside the girdle, did a little more wiggling, things felt better for the moment. She smiled a little bit and started up the steps.

What she didn't know was that behind two chairs were two seven-year-old boys who had been playing truant from school. They had seen the whole operation. So they go up very slowly from behind those chairs and one said to the other: "Gee, I wonder how Dick Tracy is going to get out of that one." (Laughter)

But I do want to say to you of the New Jersey Society that Mrs. Orr and I have most deeply appreciated the many kindnesses and the favors and the hospitality you have shown us. We have truly enjoyed being guests of, shall I say, the little A.M.A., because this certainly has been a small meeting of the American Medical Association in every possible way.

Quite apart from the interest and the affection which attract me to New Jersey as the leader of our honored profession, I am drawn to The Medical Society of New Jersey for its paradoxical combination of the wisdom of age and the exuberant vitality of youth, for its appreciation and its understanding of the past and its realistic awareness of the future.

Members of medical societies and other groups all over the country stand in awe of the hard won knowledge and the character of a society founded back in 1766. One hundred ninety-three years bear witness to the worth and the dependability of high professional services which all men and women of American Medicine honor and acclaim. But despite its years there is no evidence that your Society today is any way less ardent and eager for the service of medicine and the people than it ever was.

I see in your President Gardner the reflection of the character of your Society. He is disciplined in the intelligent awareness of all that has transpired and is ready to face realistically and has faced realistically whatever of challenge or difficulty the present or the future may hold.

Therefore, tonight on behalf of the members of our lofty profession, on behalf of the American Medical Association which I have the honor to represent—one of whose most splendid assets and ornaments it owes to you in the person of my great friend, Dave Allman—I sing the praises of The Medical Society of

New Jersey, and I hail your President and his lovely lady. Thank you. (Applause)

THE TOASTMASTER: Thank you very much, Dr. Orr, for them kind words. We have tried to take care of you since you have been here and we hope you have enjoyed your stay with us.

You are coming back again on June fifth with the AMA convention and I will be busy then as General Chairman and I know darn well you will want to go places that you won't be able to get into without a key, so the Mayor sent a key for you. (Applause)

And, Clyde, I picked up a third one for you. I didn't give it to you previously because I wanted our outgoing President to get his. But here is one for you and you can go every place that Ken Gardner goes, not at the same time. (Applause)

That concludes the official part of our program. I think Ken has properly thanked most people. I'd like to thank Joe Stern and his men for the fine music they provided us with; the hotel for the dinner and the fine service.

The balance of the entertainment of the evening until the dancing starts will be rendered by the Doctors' Chorus of the Essex County Medical Society and the Women's Choral Group of the Woman's Auxiliary to the Essex County Medical Society. And I will turn it over now to Dr. Kavanaugh, who will proceed with his musical presentation.

(The speakers' section was concluded at 9:25 p.m.)

Obituaries • • •

DR. FREDERICK AUERBACH

Dr. Frederick Auerbach died on January 10 at the age of 62. Born in Vienna, he had been graduated in 1923 from the medical school of the University of Vienna. He subsequently did graduate work in Breslau and in 1938 came to New York City. After two years of practice in that city, he moved to Irvington, whose people he served steadily since 1940. Dr. Auerbach was proud to be known as a general practitioner and was active in the affairs of the New Jersey Academy of General Practice.

DR. HAROLD S. DAVIDSON

Dr. Harold S. Davidson, a national past-president of the American Therapeutic Society, died on February 18 at his Atlantic City home. Born in 1892, Harold Davidson was graduated in 1915 from the Jefferson Medical College. He took a residency in pathology after his internship and then entered the Army Medical Corps in 1918. After 2 years of foreign service, he was mustered out and established his office in Atlantic City for private practice. He became increasingly interested in internal medicine and served the Atlantic City Hospital in that service and in all grades from clinical assistant to chief of medicine there. He also had a tour of duty as president of the medical staff of the Atlantic City Hospital. He was a diplomate of the American Board of Internal Medicine.

DR. MAX GREENBERG

After a quarter of a century of service as Linden's City Physician, Dr. Max Greenberg died in Linden on January 11 at the age of 65. Dr. Greenberg had been graduated in 1924 at Hahnemann Medical College of Philadelphia. Prior to entering medical school he was a psychologist and served in the Army of the United States in 1918 as a specialist in psychological warfare. Dr. Greenberg was interested in geriatrics and internal medicine and was affiliated with the St. Elizabeth's Hospital in those departments. He was active in library administration and for almost 30 years was a member of the Linden Library's Board of Trustees. He also had a tour of duty as president of that library. He served as president of the Linden College Club. Dr. Greenberg was an amateur wood carver of more than local repute and a few years ago was the winner of the AMA's first prize for art work by physicians.

DR. SAMUEL W. HAUSMAN

Dr. Samuel W. Hausman, past-president of the Monmouth County Medical Society, died in Florida on New Year's Day. Born in Sodus, New York, in 1886, he earned his M.D. at Syracuse University in 1916. Four years later, he came to Red Bank and served the people of the shore area for 40 years. He held a preacher's license at the local Methodist Church. He served as president of the Red Bank Rotary Club. He was a member of the Red Bank Board of Health, and had been president of the local YMCA. Dr. Hausman was a pioneer in the practice of pediatrics and was affiliated with Fitkin, Riverview and Monmouth Hospitals.

DR. HARRY NELSON

Dr. Harry Nelson, age 63, a member of the Underwood Hospital staff in Woodbury since 1926, died January 7, at the Washington Sanatorium, Washington, D. C. Dr. Nelson resided in Woodbury. He was born in Franklin, Pennsylvania, and spent most of his boyhood in Salem County, N. J. He was a 1923 graduate of the University of Pennsylvania Medical School. He was a member of the American Fracture Association, Philadelphia Medical Club, and Philadelphia Doctors Golf Association. Dr. Nelson was widely recognized as a traumatic surgeon.

DR. CHARLES E. ROSEN

Dr. Charles E. Rosen, president of the Hudson County Medical Society died on January 19 at the untimely age of 46. A native of Hoboken, Dr. Rosen lived most of his life in Union City. In high school and college he was a well-known football player. He received his M.D. in 1939 at New York Medical College. After his internship, he entered the Air Force and served two years in India and then established an office in Union City for private practice. Although he always considered himself a general practitioner, Dr. Rosen was especially interested in surgery, gynecology and obstetrics. He was an associate surgeon at Christ Hospital in Jersey City, and attending in obstetrics and gynecology at St. Mary's Hospital in Hoboken. Active in the Hudson County Medical Society, he served that society in many offices, and was installed as president last September. He was also physician to the Union City schools and a member of that municipality's Board of Health.

DR. HOVSEP TATARYAN

Director of the child hygiene department of Union City, Dr. Hovsep Tataryan died on February 6 at his home in Union City. Born in Turkey in 1889, he received his M.D. in 1914 from the medical school of the American University in Beirut, Lebanon. He then was commissioned in the British Army Medical Corps, and on being mustered out in 1918 he came to the United States. In 1919 he moved to Union City, and has since then served the people of Bergen and Hudson Counties. Since 1921 he was a city physician, rising in the ranks from assistant physician to director of child hygiene. He was also affiliated with the surgical staff of Christ Hospital.

DR. CALVERT R. TOY

On the morning of February 6, 1960, Dr. Calvin R. Toy died at St. Peter's Hospital, New Brunswick, where he was a consultant in internal medicine. Born in North Carolina in 1899, he earned his M.D. at the University of Pennsylvania in 1923. He started in general practice but soon became interested in, and eventually devoted himself to internal medicine. He became a Board diplomate in that specialty. Dr. Toy served in both world wars, being in the infantry in World War I. He was a lieutenant colonel, Medical Corps, in World War II. He was active in the affairs of our Middlesex County Medical Society, the local chapter of the American College of Physicians, and was affiliated with both New Brunswick Hospitals.

DR. BENEDICT P. WILLIS

Dr. Benedict P. Willis, director of surgery at St. Mary's Hospital in Passaic died of a heart attack at his home on January 30. Born in Rutherford in 1888, Dr. Willis devoted his entire life to the people of the Bergen-Passaic area. In 1912 he received his M.D. at Bellevue. Two years later he opened his office for general practice in Rutherford but soon began to specialize in surgery. He served St. Mary's Hospital in all grades in its surgical service eventually becoming director of surgery there and president of the senior staff. He was a director of the Community Bank and a trustee of St. Mary's Church. Dr. Willis was a Fellow of the American College of Surgeons.

Erratum

In the article on Wegener's granulomatosis on page 32 of the January issue, the entity was referred to in the resumé as "Wegener's syndrome." Dr. Friedenberg points out that this is not strictly speaking a syndrome and that the preferred form is Wegener's granulomatosis.

Announcements • • •

For Senior Practitioners Only

Dr. J. H. McCurry, of Cash, Ark., advises that he has the approval of the American Medical Association to organize a Fifty-Year Club within the AMA. Dr. McCurry is anxious to hear from physicians who have been in practice fifty years or more who desire to become members of this club, giving their name and a complete address.

The first meeting is to be held in Washington, D. C. at the Clinical meeting November 29 to December 2, 1960.

EENT-Esophagoscopy Congress

Slated for the heart of the Blue Ridge Mountains, April 4 through 9, is the 33rd Congress of the Gill Eye, Ear and Throat Hospital, Roanoke, Virginia. A practical program has been formulated, presented by an all-star faculty. Registration fee is $40 for the 3-day program or $80 for the 6-day program. For more details, write to Dr. E. G. Gill at 711 South Jefferson Street, Roanoke, Virginia.

Venereal Disease Meeting

A symposium on recent advances in venereal disease is scheduled for April 7 and 8 at the Palmer House in Chicago. Details may be obtained from Commissioner of Health, Trenton 25, N. J. The session is open to all interested workers in the health field.

Malabsorption Syndrome

A symposium on the malabsorption syndrome is scheduled for Wednesday, March 23, at the Essex House, 1050 Broad Street, Newark. The meeting is under the aegis of the New Jersey Gastro-Enterologic Society and starts promptly at 2 p.m. For more details, write to Dr. Louis Brodkin at 825 South Tenth Street, Newark.

Symposium on Congenital Heart Disease

In Philadelphia, Thursday, April 28 through Saturday, April 30, there will be held a compact colloquium on congenital heart disease. Sponsored by the Deborah Hospital, this meeting will bring together experts in this field from all parts of the world. There is no registration fee. Interested physicians may obtain full details from Deborah Hospital Director, 901 Walnut Street, Philadelphia 7.

Bacteriology Colloquium

Philadelphia will be the site of the 60th Annual Meeting of the Society of American Bacteriologists.

The meeting, to be held May 1 through 5, will feature 400 papers dealing with latest research findings in bacteriology and microbiology. A detailed program may be obtained from Mr. D. M. Cleary, Box 354, Upper Darby, Penna.

Advances in Pediatrics

A compact course in "advances in pediatrics" is available in Philadelphia during the four-day period beginning May 30. Tuition is $115 and registration is limited. For details, write to Director of Graduate Education, Children's Hospital, 1742 Bainbridge Street, Philadelphia 45, Penna.

County Society Reports • • •

Atlantic

The regular meeting of the *Medical Society of Atlantic County* was called to order by President Louis Rosenberg at 8:55 p.m. on January 8 at the Children's Seashore House. Report was made of a letter from Benjamin Rimm, acting Director of Welfare, in which he stated that there has been a change in the payments to medical vendors in the administration of the home life assistance program. This will be transferred to the jurisdiction of the Atlantic County Welfare Board, and it was Mr. Rimm's desire that all physicians were cognizant of this change.

Mr. Thomas Halpin's letter regarding a licensure bill for physicians was referred to the Legislative Committee.

We received a letter from Atlantic County Chamber of Commerce concerning the establishment of a small claims court. It was decided that this was not under the jurisdiction of the Society.

Mrs. Edgar Warner has written to suggest that our senior citizens be informed that there is now a day center at the Richmond Avenue School.

A thank you letter was sent to Dr. Rosenberg by Norman Shamberg of the Jewish Community Center for the assistance that he gave in recent discussion at the Center.

Dr. Leonard Ellenbogen presented a resolution which was adopted by the Society concerning the Blue Cross and Blue Shield, as follows:

> *"Whereas,* the Blue Cross Plan is contemplating coverage of out-patient diagnostic services including x-ray and pathology in the out-patient departments of hospitals, and
>
> *Whereas,* Blue Cross is designed to cover only hospital services and not medical services for its subscribers, and
>
> *Whereas,* this would further increase the high cost of hospitalization insurance, and
>
> *Whereas,* Blue Shield (the Medical-Surgical Plan) has issuer an excellent rider which covers, among other things, radiology, pathology, surgery, and physical therapy in the doctor's office, and therefore a similar Blue Cross rider with its additional cost to the subscriber is entirely unnecessary and unwarranted, therefore be it
>
> *Resolved,* that the Medical Society of Atlantic County express its opposition to the Blue Cross coverage of out-patient diagnostic services including radiology, and pathology in the hospital, and be it further
>
> *Resolved,* that The Medical Society of New Jersey act with all it's resources to oppose the development of such coverage by the Blue Cross."

Dr. Max Gross discussed recent work on the new encephalitis vaccine.

Dr. Rosenberg then turned the meeting over to Mrs. Matthew Molitch for presentation of the joint program with the doctors, dentists, and pharmacists. Mrs. Clarence Whims, Chairman of Chronically Ill, presented a film, "Home Again," which depicted a patient's return home from the hospital following a heart attack. Mrs. Herbert Axilrod, Chairman of Mental Health, introduced Dr. Amadeo Barbanti, who discussed the emotional problems following a heart attack and explained how emotions are affected by physical illness and how they, in turn, affect a person's well being.

LEONARD B. ERBER, M.D.

Reporter

Bergen

The regular meeting of the *Bergen County Medical Society* held January 12 at Petrullo's Everglades Restaurant, Hackensack, was called to order by Donald B. Hull, M.D., President, at 9:20 p.m. There were forty-five members present.

The minutes of the regular meeting of December 8, 1959, and those of the Executive Committee meeting of December 15, were on motion accepted as printed in the January *Bulletin* and ordered filed.

Mr. Fincke, Executive Secretary, informed the meeting that a national effort had been launched to "Raise a Dollar Per Doctor For Dooley" and that the Executive Committee at its meeting of December 15, approved this appeal.

The President called attention to the special low cost Blue Shield contract for patients 65 or more years old, which has been mailed to each member, and asked that those who have not yet returned their signed participation agreement, do so at once. This effort to provide low cost medical care for senior citizens is endorsed by the American Medical Association, The Medical Society of New Jersey, and the Bergen County Medical Society. It constitutes one of the principal alternatives to free medical care for all senior citizens as proposed in the Forand Bill.

The Treasurer announced that 509 members had paid their 1960 dues; that 167 are still outstanding and that all 1959 dues have been paid.

The Secretary informed the meeting that none of the doctors elected at the December 8th regular meeting were present to receive certificates due to either personal commitments or the extremely inclement weather. Each is planning to attend the February meeting to receive his certificate.

Dr. Verdon, Chairman of the Constitution and By-Laws Committee, presented the first reading of the proposed amendments to the By-Laws. He explained that each of these amendments was made necessary by the State Society By-Law Amendments adopted at its Annual Meeting last April.

Dr. Hull called attention to the article on page 24 of the January *Bulletin* entitled "Don't Get Caught With Your Economics Down!" by William Alan Richardson. He recommended that all members give this article careful thought.

There being no further business to come before the meeting, the Chair announced its adjournment and introduced Dr. J. Richard Mazzara, Chairman of the Entertainment Committee. Dr. Mazzara thanked the forty-five members present for braving the sleet and snow storm raging in the County to attend this first smoker held in many years. He presented Dr. Joseph F. Videtti, who had arranged the entertainment program and announced that sandwiches and coffee would be served on the buffet.

Dr. Videtti introduced the master of ceremonies and the hour-plus show consisting of musicians, a vocalist and a magician, who was assisted by his mentalist daughter. The community singing and the feats of magic were particularly impressive.

At the end of the performance, Dr. Hull congratulated Doctors Mazzara and Videtti and hoped that the next smoker would enjoy far better weather and therefore a larger attendance.

The regular meeting of the *Bergen County Medical Society* was held February 9, at Bergen Pines Hospital.

The following were approved for membership: To Associate—Louis J. Dougherty; Dean A. Everhart. Leave of Absence—Tor Richter, military service; Ronald MacDonald, 1 year due to illness.

Dr. George Heller, Chairman of the Nominating Committee, made his report on nominations for the Annual Meeting and Councils and Committees of The Medical Society of New Jersey.

The Chair asked for additional nominations from the floor. There being none, nominations were closed.

The Chair turned the meeting over to Dr. S. B. Reich, Chairman of the Program Committee. Dr. Reich introduced Dr. Arthur Bernstein, president of the N. J. Chapter of the College of Chest Physicians, and Dr. Emanuel Klosk, secretary of that organization. Dr. Reich introduced the panel which consisted of Drs. John L. Olpp, William L. Palazzo, Eric J. Ryan, Herbert S. Sharlin and the guest panelist, Dr. Coleman B. Rabin, Chief of Chest Service and Associate Radiologist of Mt. Sinai Hospital. A brilliant panel discussion was presented which was loudly acclaimed.

CHARLES P. CAMPBELL, M.D.

Reporter

Burlington

The *Burlington County Medical Society* met December 10, 1959 at Millside Farms, President Edward Haldeman in the chair. Irving Leopold, M.D., Chairman of Ophthalmology of the Graduate School, University of Pennsylvania, talked about "Newer Concepts in Management of Diseases of the Eye," emphasizing the ability to visualize directly in the eye the vascular disorders of importance in general medicine. He also pointed out how erroneous many of our concepts of the action of vasomotor drugs are, this being the reason for many poor therapeutic results.

The Nominating Committee presented its slate for 1960 officers. Harold S. Orchow, M.D., Levittown, N. J., was unanimously elected to Regular membership. The meeting was followed by a pleasant social hour.

President Edward Haldeman called the Society meeting to order January 14, at Millside Farms. Perry MacNeal, M.D., Associate Professor of Clinical Medicine, University of Pennsylvania, gave a fascinating talk on the causes and treatment of obesity. He emphasized what a true killer this disease can be, pointing out that the death rate of the obese is about 350 per cent of normal. It is associated with diabetes mellitus, cholelithiasis, arteriosclerosis, degenerative joint disease. The one essential of successful therapy is to convince the patient of the importance of reduction, and to make him really want to reduce. With a properly motivated patient, any program will be successful. In the absence of this, the program will fail, no matter how skillfully planned.

There was considerable discussion concerning the pending bill for licensure of physical therapists, concern being voiced about whether this would prevent a doctor's nurse giving physiotherapy under his supervision. Action was deferred until more could be learned about the bill, and in particular why the state medical society was against it.

Dr. Dietrick reported on the deaths of 11 children in recent weeks occurring within 12 hours of onset of illness, with similar autopsy findings of cerebral congestion and thick mucus in the tracheobronchial tree.

The treasurer's report was satisfactory, and brought the welcome news that we were able to add $2,000 to the trust fund established for nurses' scholarships.

It was unanimously voted to accept the Interprofessional Code of Ethics between doctors and lawyers.

Dr. Owen Change of Riverton, and Dr. Alan F. Wirtshafter of Levittown, N. J., were unanimously elected to Regular membership in the Society. Dr. Donald Adrian, also of Levittown, N. J., transferred membership from Philadelphia County Medical Society to Burlington County Medical Society with unanimous approval.

The meeting was then adjourned.

LINDLEY B. REAGAN, M.D.

Reporter

Cumberland

The February meeting of the *Cumberland County Medical Society* was held February 9, 2:30 p.m., at Richards Farm, Rainbow Lake, with Benjamin Berkowitz, M.D., of Bridgeton, presiding.

John F. Fitzgerald, M.D., of Vineland, was approved for advancement to Active from Associate membership.

A resolution was read on the death of George Norfleet Thomas, M.D.

Ralph Phillips, M.D., of Bridgeton, Chairman of the Diabetes Drive, lauded the assistance given by the county mayors, Mr. Jerry Alden of WSNJ, and the county newspapers, the Bridgeton Evening *News*, the Atlantic City *Press*, Vineland *Times Journal* and the Millville *Republican*, in his final report.

Dr. Phillips cited that of the 691 tests conducted by the county physicians, 9 proved positive, showing 1.3 per cent new cases. The Dreypaks tested numbered 1,501 with 12 positive cases or 0.8 per cent new cases. The national average for new cases was 1.2 per cent.

Dr. Phillips concluded his report with a special commendation to the Woman's Auxiliary for their fine cooperation.

The main speaker was Earl Halligan, M.D., head of the Department of Surgery, Seton Hall School of Medicine; and Medical Director, Medical Center, Jersey City. He spoke on "Gastrointestinal Tract Hemorrhage." Dr. Halligan's discussion was both informative and interesting.

The meeting adjourned to collation.

LEONARD G. SCOTT, M.D.

Reporter

Gloucester

The regular monthly meeting of the *Gloucester County Medical Society* was held in the Woodbury Country Club on December 17, 1959.

The guest speaker was Dr. Paul Nemir, Jr., Dean of the Graduate School of Medicine at the University of Pennsylvania, who delivered an enlightening talk on "Surgical Management of Lesions of the Aorta and Great Vessels."

Subsequent to this, the business portion of the meeting was held. Dr. Samuel Porter was elected a member of the Society. The proposed revisions of the constitution were read by Dr. James Kehler. A new site of our meeting place was discussed and a committee was appointed to investigate the possibilities.

The regular monthly meeting of the *Gloucester County Medical Society* was held January 21 at the Woodbury Country Club. Speaker of the evening was Dr. Richard J. Coyne, Director of Research and Development for Smith Kline & French. He gave an enlightening discussion on pharmaceutical research, and the meeting was jointly attended by the pharmacists from the Camden and Gloucester County Pharmaceutical Association.

Following Dr. Coyne's delivery, a discussion was held and subsequent to this a business meeting in which the minutes of the last meeting were approved, the treasurer's report was given by Dr. Booth. It was on a sad note that the Society accepted with regret the resignation of our Executive Secretary, Mrs. Marian Chew, who has performed many outstanding services. It was announced by Dr. Campo that a course on new methods of cardiac auscultation at the Woodbury Country Club would be held from March 16 to May 18 on Wednesdays from 3 to 4 p.m.

The meeting was followed after adjournment by a very tasty collation.

WILLIAM D. KEHLER, M.D.

Reporter

Hudson

With Dr. Charles A. Landshof presiding the regular meeting of the *Hudson County Medical Society* was held at Murdoch Hall, Jersey City Medical Center on February 2.

The guest speaker of the evening was Mr. Louis Oppenheim, Special Agent of the Northwestern Mutual Life Insurance Company. Mr. Oppenheim spoke on life insurance and the physician.

The following Resolution was unanimously adopted:

Whereas It has pleased Almighty God in His divine providence to remove from us by death, our esteemed colleague and our faithful friend, Charles E. Rosen, M.D.

Who, by his zeal and energy, his strict devotion to the interests of his fellow-man and the highest ideals of ethical medical practice has endeared himself to all with whom he came in contact, and

Whereas, He has faithfully served the Hudson County Medical Society as a loyal and trusted member for many years and

Whereas, at the time of his untimely demise he was President of the Society, therefore be it

Resolved, That we give expression to our feelings of heartfelt sorrow on the occasion of his death; and we extend our most sincere sympathy to the grieved family in this their sad affliction, and be it further

Resolved, That this Resolution be spread upon the minutes of this meeting, and a copy, suitably engrossed, sent to the family on which he centered his life's devotion.

The vote on the amendments to the Constitution and Bylaws was postponed until the next meeting.

Dr. Landshof announced that the Sixth Annual Dinner Dance of the Society would be held on Saturday evening, April 30, at the Hotel Essex House, Newark.

Following the business meeting a collation was served.

ROY A. MORROW, M.D.

Reporter

Mercer

Action taken at the *Mercer County Component Medical Society's* February 10, 1960 meeting included: election of officers for the year 1960-61, as follows:

President, Dr. Peter J. Warter; *Vice-President*, Dr. Walter R. Peterson; *Secretary-Reporter*, Dr. I. Frank Bird and *Treasurer*, Dr. Robert J. Ryan.

A motion was passed that the Society sponsor two graduate courses (one in medicine and one in surgery), under the auspices of Seton Hall College of Medicine and Dentistry, during 1960-1961.

R. N. CAGAN, M.D.

Reporter

Middlesex

A symposium on medical-legal problems was the main feature of the joint meeting of the Middlesex County Bar Association and the *Middlesex County Medical Society* held on January 20 at a dinner meeting beginning at 7:00 p.m. at the Oak Hills Manor in Metuchen. Dan Golden, Esq., was the chairman for the evening.

Dr. Earle N. Rothbell of Colonia, was elected to Regular membership from two years' Associate membership.

Following an excellent steak dinner, the speakers on the symposium: Dr. William G. Kuhn, Jr., Dr. William C. Wilentz, and Barry Seidman, Esq., presented their ideas on the medical-legal problems between the two professions and suggested ways of meeting these problems.

A liaison committee was set up between the two societies.

THOMAS I. STEINBERG, M.D.

Reporter

Monmouth

Dr. Lester Barnett, president of the *Monmouth County Medical Society* called the meeting to order at 9 p.m., January 27. Dr. Harold Gabel of Elberon was then introduced as moderator of the evening panel. Its topic was "The Forand Bill and You."

Dr. Gerald F. Whelan of Red Bank discussed problems of medical practice in Great Britain and showed how we could learn from their difficulties. The Forand Bill at the national level was reviewed by Dr. C. Byron Blaisdell. Then Dr. Daniel F. Featherston of Asbury Park spoke on "The Forand Bill at the State Level." Possibilities of action at the local level were then reviewed by Dr. Anthony De Spirito of Asbury Park.

A business meeting followed the spirited panel discussion. Dr. Ralph Carbone of Hazlet was elected to active membership on transfer from our Bergen County component.

Dr. Barnett called for a vote of thanks to the Public Relations Committee under the chairmanship of Dr. Donald W. Bowne for a wonderful job in providing the local press with articles explaining the high standards of medical practice. Dr. James Fisher, Sr., read a eulogy noting the outstanding service of the late Dr. Samuel W. Hausman of Red Bank.

A resolution was passed opposing the plan for providing payment by Blue Cross for x-ray services to be done in out-patient departments of hospitals. Past president Dr. David W. McCreight presented the panel of officers for the coming year. These will be published in the next report.

LEONARD S. DANZIG, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on January 19 at 9:00 p.m. at the St. Joseph Hospital in Paterson. The occasion was the Fourth Meyer Notkin Memorial Lecture, co-sponsored by the Society and by the Passaic County Heart Association.

Dr. Cohen, president of the Passaic County Medical Society, welcomed those attending, stating that he felt particularly honored, since he was the past president of the Heart Association. He spoke highly of the late Dr. Meyer Notkin, not only for the outstanding work he did for the Heart Association and St. Joseph Hospital, but also for all of the people that he helped.

The following were elected to Associate membership: Drs. Victor J. Irmiere of Wayne; Carlos M. Cane and Nayade G. Cane of Clifton; Sidney Fink, E. Robert Wilson and Theodore Harami of Pater-

son; and Ralph N. Bloch of Oakland. Elected to Active membership by transfer from the New York County Medical Society was Dr. Vincent A. Scialli of Passaic.

Dr. Cohen read a letter from Dr. Clyde Bowers, President of The Medical Society of New Jersey, regarding a "Senior Citizen's Contract" to be made available to persons over 65 with reduced income limits of $2,000 for a single person and $3,000 for a couple. Since this program must have the endorsement, by contractual agreement, of at least 51 per cent of the physician population of each county, the letter urged that all physicians, regardless of specialty, sign this contract. Dr. Cohen stated that if the Society members want to prevent socialized medicine, they should cooperate with a program of this type.

Dr. Jehl, Chairman of the Insurance Committee stated that there had been a misunderstanding in regard to the letter sent to all the members about major medical insurance. It was the intent on of the Insurance Committee to poll the membership, and if sufficient replies were received to warrant it, the Insurance Committee would investigate further.

The meeting was then turned over to Dr. Gordon W. Howe, who addressed the group on the functions of the Heart Association. Dr. Howe called upon Dr. David Roth, Program Chairman of the Passaic County Heart Association, who introduced the guest speaker of the evening, Daniel F. Downing, M.D., Associate Professor of Pediatrics, Hahnemann Medical College.

At the conclusion of the program, a collation was served by the St. Joseph Hospital

IRVING CHRISMAN, M.D.

Reporter

Salem

The *Salem County Medical Society* held its regular monthly meeting at the DuPont Penns Grove Country Club on January 15, with Dr. George A. Nitshe of Elmer, presiding.

William L. Sprout, M.D., of Salem, announced that a majority of the physicians of Salem and Cumberland counties had signed contract agreements endorsing the "Senior Citizens Contract" of the Medical-Surgical Plan of New Jersey. This is a plan for those over 65 years of age, and who have incomes not exceeding $2000 for a single person and $3000 for a couple. Acceptance of this agreement by individual physicians indicates their willingness to take reduced fees for the professional services which they will render to subscribers of the Senior Citizens Contract. It was also noted that these two neighboring counties are the first in New Jersey to support this new contract.

The chairman of the Rheumatic Fever Committee of the Salem County Heart Association, Harry A. Suter, M.D., informed the group of the formulation of registration cards for rheumatic fever patients receiving antibiotic drugs under the supervision of their attending physician. The cards will be distributed to physicians who request them from Dr. Harry F. Suter of Penns Grove or Dr. Donald McLean of Salem.

Harry J. Hurley, M.D., Professor of Dermatology at Hahnemann Medical College, was the guest speaker for the evening. His topic was *Recent Advances in Dermatology*. Through the use of colored slides, Dr. Hurley illustrated his very interesting cases as he discussed them. A short question period was held prior to dinner.

G. F. REICHWEIN, M.D.

Reporter

Medical Sales Representatives Play Santa Claus

One of the quieter but more effective of the truly philanthropic organizations in the state, is the New Jersey Medical Sales Representatives Association, which in addition to sponsoring educational programs for physicians, also each year develop something especially for children. In 1959 they distributed toys, individually wrapped to under-privileged children in Northern New Jersey. THE JOURNAL is pleased to recognize this worthy activity.

Ophthalmology Fellowships Available

The Guild of Prescription Opticians announces that fellowships are available in ophthalmology, representing an annual stipend of $600, or $1800 for a 3-year residency. For application forms and details, write to Guild of Opticians, 110 East 23 Street, New York 10, N. Y.

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Gynecologic and Obstetric Pathology. By E. Novak and E. R. Novak. Philadelphia, 1958. Saunders. Ed. 4. Pp. 650. ($14.00)

This book has for years held an enviable position in its field. Death of the senior author during the production of this edition makes it particularly meaningful to all who knew and respected Emil Novak.

The structure of the text has been continued in a sound fashion. Changes have been made in keeping with modern developments in cytology. Chapters dealing with the placenta have been revamped. Such problems in pathology as the relationships of endometrial hyperplasia and adenocarcinoma of the corpus, and basal cell hyperactivity and carcinoma of the cervix are discussed at some length. The authors never lose sight of the clinical approach. This plus the style of writing keep this treatise alive.

The book continues to hold its position as an authoritative reference for both the pathologist and the clinician.

H. P. Shipps, M.D.

Clinical Auscultation of the Heart. By Samuel A. Levine, M.D. and W. Proctor Harvey, M.D. Philadelphia 1959, Saunders. Pp. 657 with 660 illustrations. ($11.00)

A book of six hundred and sixty pages on heart sounds might seem discouraging even to the physician interested in heart disease. However, this second edition by two great bedside teachers is a classic study of heart disease. It introduces the reader to the proper use of the stethoscope. Such simple details as length and internal diameter of stethoscope tubing, the degree of pressure one applies to the chest, the adjustment of ear pieces are discussed in logical concise language. The authors also include a usable description of normal heart sounds and the dynamics of their production. Variations from these normals are introduced in a logical sequence. Emphasis is on the use of the stethoscope for diagnosis of specific cardiac lesions. The description of cardiac arrhythmias gives the best account of these perplexing emergency conditions this reviewer has read.

Rheumatic heart disease, now so often forgotten, receives careful attention. Its anatomic cardiac lesions are well described. By careful analysis of the sounds heard, as the examiner hears them, one follows the logic used by these two competent cardiologists to a working diagnosis. In doing so, the practitioner grasps the "sorting out" process used and is thus forced to recognize the causes of the confusing murmurs and sounds.

The section devoted to congenital heart disease has been expanded in light of the recent advances of cardiac surgery. Especially intriguing are descriptions of heart sounds after corrective surgery.

The greater size of this edition is due largely to the greater number of phonocardiographic and electrocardiographic tracings included. Although helpful, the extra tracings are really not needed to make this a valuable monograph on heart disease. This volume differs from the usual textbook approach in terms of physical signs heard over the heart and not on the more usual framework of etiology or pathology. By coming to the subject as the examining physician approaches the examination of the patient, one can visualize the basis for the patient's symptoms with assurance. The reader is repeatedly warned against undue reliance on machines, such as the phonograph. The authors show that they are valuable laboratory tools but that they do not supercede the physician's senses, sharpened by intelligent experience.

Chester B. Allen, Jr., M.D.

Pathophysiology in Surgery. By James D. Hardy, M.D. Baltimore, 1959. Williams and Wilkins Company. Pp. 704. ($19.00)

Single authorship books are becoming a rarity, particularly in such an all-inclusive subject as pathophysiology in surgery. Doctor Hardy has presented a remarkably complete treatise. He has been conscientious in presenting the publications of many authors. This has, at times, almost sacrificed some of the advantages of "single authorship." The reader found himself occasionally wondering what Doctor Hardy thought about a particular controversial subject.

The first ten chapters cover basic physiology. The next eleven deal with the surgical diseases of various organs, describing the physiology of the organ followed by pathologic changes, indicating

the measures instituted in correcting these conditions. Diagrams very cleverly simplify some of the more complex pathophysiologic problems. One could profitably spend an entire evening studying the diagrams in the chapters on liver, gallbladder, biliary tract and the pancreas.

This book should be in every serious medical library. It presents an excellent, concise explanation of the pathophysiology of most of the conditions which surgeons are called upon to treat. In fact, all who have been away from their academic training for a few years should own this book and use it frequently for review and reference.

HARRISON R. WESSON, M.D.

That the Patient May Know. Harry F. Dowling, M.D. With drawings by Tom Jones and Virginia Samter. Philadelphia 1959. Saunders. Pp. 139. ($7.50)

It's about time somebody wrote this book. Here are hundreds of illustrations, drawn with clarity and simplicity, illustrating body processes and structures. The primary purpose of this atlas is to enable the doctor to show the patient schematically, exactly what is meant by an ulcer or anemia; to show him how the ear is related to the throat; to show what happens in an allergic spasm and so on. The book will also be useful in preparing illustrations for talks to lay groups. Included are such relatively abstract concepts as the effects of anxiety on body organs; such concrete ones as the anatomy of a boil; such useful ones as self-examination of the breast. The low price ($7.50) is possible only because of contributory support by Lederle Laboratories. This book is well worth the space on top of any doctor's desk.

ULYSSES M. FRANK, M.D.

Breast Cancer. Edited by Albert Segaloff, M.D. St. Louis, 1958. Mosby. Pp. 257. ($5.00)

This book is a record of The Louisiana Cancer Conference held in January 1958. Breast cancer was considered from the point of view of both the clinician and his laboratory associates. The record of the conference is well worth study by persons concerned with the care of patients having mammary cancer.

The basic biology and definitive treatment of the disease are discussed. Comment is made on the role of surgery, radiation and hormones.

The section devoted to pathology was of particular interest to the reviewer. A clear demonstration of the morphologic variability of breast cancer is given. All known types may be found in one tumor, thus suggesting morphologic grading to be of little value.

Difference of opinion as to the worth of extended radical surgery for breast cancer is noted. The classical Halsted radical mastectomy continues to remain appropriate surgical therapy except in special circumstances. Supraclavicular tumor spread is an ominous sign.

The book is well indexed and attractive typographic composition helps make it very readable.

ROBERT K. SPIRO, M.D.

Management of Complications in Eye Surgery. Edited by R. M. Fasanella, M.D. Philadelphia, 1957. Saunders. Pp. 421. ($16.00)

Careful reading of this book will help the less experienced surgeon avoid pitfalls which are always awaiting the busiest surgeon or clinic. To improve his technic, every surgeon has to borrow from the successes and learn from the failures of others, and this book offers a unique and painless way of doing that.

Some of the complications touched on in this volume are: complications associated with foreign bodies in the eye, with anesthesia, with ptosis surgery, with keratoplasty, with evisceration, and with plastic surgery of the eyelids. Each chapter is written by a distinguished plastic surgeon.

Since it is easier to avoid the pitfall than to manage the complication, this is a particularly valuable guide.

THOMAS D. MONTE, M.D.

Gray's Anatomy. Edition 27, edited by Charles Mayo Goss. Pp. 1458 with 1200 illustrations. Philadelphia, 1959. Lea and Febiger. ($17.50)

In 1859, Blanchard and Lea of Philadelphia published the first edition of *Anatomy* by Henry Gray. Two years later, at the age of 34, Henry Gray was dead of smallpox contracted from a patient. But his *Anatomy* survived. By now there have been 32 British and 27 American editions. More than a half a million copies of the American edition have been sold.

Writing a critical review of Gray's *Anatomy* is like setting out to criticize Shakespeare. This is the old reliable of medicine, the cornerstone of more medical educations than any book ever written. The current edition brings in new material on the endocrine gland and has rewritten the anatomy of the heart in the light of current surgical interest. Material on embryology has been clarified and expanded. Advantage has been taken of newer technics of photography and picture reproduction. But the editors have not touched the basic, familiar illustrations and the simple straight-forward text. You can't blame them. For a medical practitioner to look through *Gray* is like coming home again. Welcome home!

HENRY A. DAVIDSON, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

March, 1960 • Vol. XXXII, No. 3

CHEMOTHERAPY OF EXTRAPULMONARY TUBERCULOSIS IN ADULTS

The treatment of extrapulmonary tuberculosis follows the general principles of chemotherapy used in the management of pulmonary tuberculosis. A suggested outline for chemotherapy is given. Prolonged treatment and a delay in instituting surgical measures are recommended.

The management of pulmonary tuberculosis varies considerably to meet problems of individual cases, but the following general principles of chemotherapy, which are widely followed, are also believed to apply to many forms of extrapulmonary tuberculosis:

1. Antibacterial chemotherapy is recommended for all patients with active tuberculosis infection.

2. Chemotherapy should be intensive and uninterrupted. Most physicians, but not all, advise combined chemotherapy, using isoniazid with either PAS or streptomycin. When it is well tolerated, PAS is usually employed because it is easily administered. Some physicians prefer to use three drugs—isoniazid, PAS, and streptomycin—for more severe manifestations of tuberculosis. The usual dosage of isoniazid is 100 mg. three times daily (3-5 mg. per kilo body weight), but there is growing indication that larger doses are sometimes more beneficial. Larger doses require the administration of pyridoxine to minimize the risk of neurologic complications(peripheral neuritis). PAS is given in maximal tolerated doses, ordinarily 4 gm. three times daily (150-200 mg. per kilo body weight). Daily administration of streptomycin 1.0 gm. (15-20 mg. per kilo body weight)—is ordinarily reserved for severe manifestations of tuberculosis, and injections every second or third day appear adequate for many cases.

3. Chemotherapy is continued for a prolonged period—usually two years and at least one year—after the tuberculosis has become inactive, as determined by x-ray, bacteriologic, and clinical diagnostic methods.

4. Surgical treatment for pulmonary tuberculosis, particularly pulmonary resection, is ordinarily delayed for at least several months. This long preliminary course of medical treatment sometimes obviates the need for surgery, usually diminishes the risk of tuberculous complications of surgery, and sometimes permits more conservative operations than would have been necessary earlier in the course of the illness. At other times lesions that appear to be inoperable improve substantially as a result of medical treatment and become operable. In some forms of extrapulmonary tuberculosis, it is probable that surgery, particularly the radical procedures, should be similarly delayed for several months after medical treatment is begun.

SKELETAL TUBERCULOSIS

When affected by tuberculosis, a weight-bearing joint is more likely to require surgical fixation than a non-weight-bearing joint. Peripheral joints heal more rapidly and completely than proximal joints. Joints of the spine are more difficult to treat than joints of the extremities.

Tuberculosis which involves only the synovial membrane is often completely reversible, and a functional cure is usually possible with chemo-

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A Statement of the Committee on Therapy, American Trudeau Society, *The American Review of Respiratory Diseases, March, 1960.*

therapy. Early diagnosis of such a condition may require biopsy.

The fusion of tuberculous joints is best delayed until medical treatment has diminished soft tissue reaction, closed any draining sinuses present, and stabilized the pathologic process, and may be avoided altogether in many instances.

Tuberculous abscesses should be evacuated when possible to facilitate healing.

TUBERCULOUS LYMPHADENITIS

Tuberculous lymph nodes often resolve rather slowly under treatment with specific drugs, but eventual healing is usually possible without surgery. Abscesses associated with tuberculous lymph nodes should be evacuated (aspirated) and occasionally resected. Acid-fast bacilli that are not typical *M. tuberculosis* are occasionally found to cause lymphadenitis. These organisms are usually not responsive to antituberculosis drugs.

GENITOURINARY TRACT TUBERCULOSIS

Tuberculosis cystitis responds promptly when the infection is recent and superficial. Despite early clearing of symptoms of cystitis, prolonged treatment is essential for permanent results.

Renal tuberculosis demands prolonged medical treatment in all cases—for even longer periods than in the case of pulmonary diseases—and results are frequently satisfactory, even without resection of seriously damaged kidneys. Opinion among surgeons is divided as to what constitutes an indication for nephrectomy.

Tuberculous epididymitis, seminal vesiculitis, and prostatitis respond slowly but definitely to adequate and prolonged chemotherapy.

Tuberculosis of the female genital tract frequently requires surgery in addition to chemotherapy, especially removal of the abscesses associated with tuberculous salpingitis. Tuberculosis of the endometrium is usually secondary to tuberculosis elsewhere in the genital tract but appears to respond to medical treatment.

MILIARY TUBERCULOSIS AND TUBERCULOUS MENINGITIS

These forms of tuberculosis may frequently be treated successfully, especially when early, intensive, and prolonged therapy is administered. Isoniazid is considered the most important drug. Streptomycin is usually employed daily for a few weeks or months. There is growing evidence that the adrenal corticosteroid hormones are beneficial. Intrathecal therapy is rarely used in the treatment of tuberculous meningitis.

Thomas B. Barnett, M.D.; Edward Dunner, M.D.; H. Corwin Hinshaw, M.D.; Gardner Middlebrook, M.D.; Donald L. Paulson, M.D.; James W. Raleigh, M.D.; William W. Stead, M.D.; Col. James A. Wier, M.C., *Chairman*.

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*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

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Ideally, selection of the proper antibiotic for treatment of acute pharyngitis should await the laboratory reports on the susceptibility of the infecting bacteria. But the busy practitioner who sees many patients a day during the upper respiratory infection season may sometimes find it difficult to avoid the empirical choice of an antibiotic. Unfortunately, this practice may sometimes result in therapeutic failure.

No matter what the pressure of the immediate situation, it is worthwhile to consider taking a bacterial specimen from the infected pharynx for culture and sensitivity studies before starting treatment. Thus, a rational basis will be provided for changing the antibiotic should the first choice prove ineffective.

Which Antibiotic?

All other things being equal, the drug of choice is the one to which the pathogen is most susceptible. But if the exigencies of the situation force the physician to a prompt use of antibiotic, a broad-spectrum preparation that produces immediate high blood levels (e.g., tetracycline phosphate complex. TETREX) probably has the best chance of controlling the pathogen.

Later, the laboratory report frequently may indicate that any one of several antibiotic agents would be equally effective against the particular microorganism in question. In such a case other factors such as frequency and severity of side effects, sensitizing potential and toxicity should be considered.

If the acute pharyngitis in question should be due to gram-negative Klebsiella[1], penicillin will be of no value, nor will erythromycin be effective. However, this organism is susceptible to tetracycline. If the pathogen should turn out to be gram-positive Streptococcus or Staphylococcus, then penicillin, erythromycin, and tetracycline may all be effective against it.

Penicillin, however, in addition to having a limited spectrum, also causes many minor and some serious sensitivity reactions. In a recent survey[2] it was found that penicillin produced severe skin reactions. But most important was the observation that anaphylactic shock, with a fatality rate of about 9 per cent, was the most frequent serious reaction. Such severe reactions are almost always associated with parenteral administration.

The tetracyclines (e.g., TETREX) have the advantages of a broad range of antimicrobial activity and low toxicity. And in addition, the physician does not have to trouble himself or his patients with repeated blood studies when he prescribes TETREX. Minor reactions such as gastric upsets or mild skin rashes occur occasionally. The most serious side effects are staphylococcal and monilial overgrowth, but these are rare and can be adequately controlled.

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[a] Some strains are not susceptible.

[b] Table adapted from Goodman, L. S., and Gilman, A.: The Pharmaceutical Basis of Therapeutics, 2nd edition, New York, The Macmillan Co., 1956, pp. 1322-1323.

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References: 1. Ayd, F. J., Jr.: Bull. School Med., Univ. Maryland *44*:29, 1959. 2. Azima, H., and Vispo, R. H.: A.M.A. Arch. Neurol. & Psychiat. *81*:658, 1959. 3. Lehmann, H. E.; Cahn, C. H., and de Verteuil, R. L.: Canad. Psychiat. A. J. *3*:155, 1958. 4. Mann, A. M. and MacPherson, A. S.: Canad. Psychiat. A. J. *4*:38, 1959. 5. Sloane, R. B.; Habib, A., and Batt, U. E.: Canad. M.A.J. *80*:540, 1959. 6. Straker, M.: Canad. M.A.J. *80*:546, 1959. 7. Strauss, H.: New York J. Med. *59*:2906, 1959.

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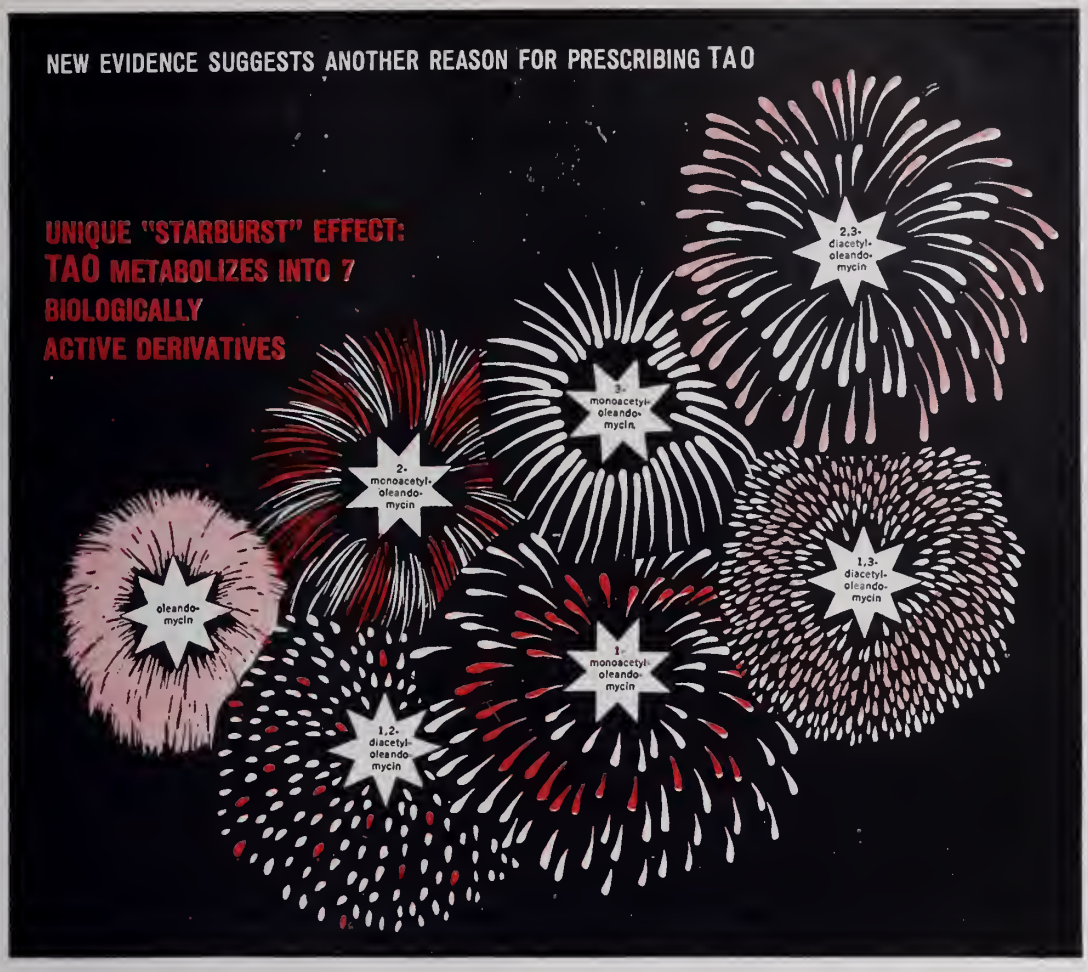
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1. Karnaky, K.J.: Med. Record and Annals, Houston 46:296 (Nov. 1952).

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*Peterman, R. A.: Clinical report cited with permission.

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a.

Fortunately, no. Often only two steps are necessary: (1) control of the amount of calories and of dietary fat, and

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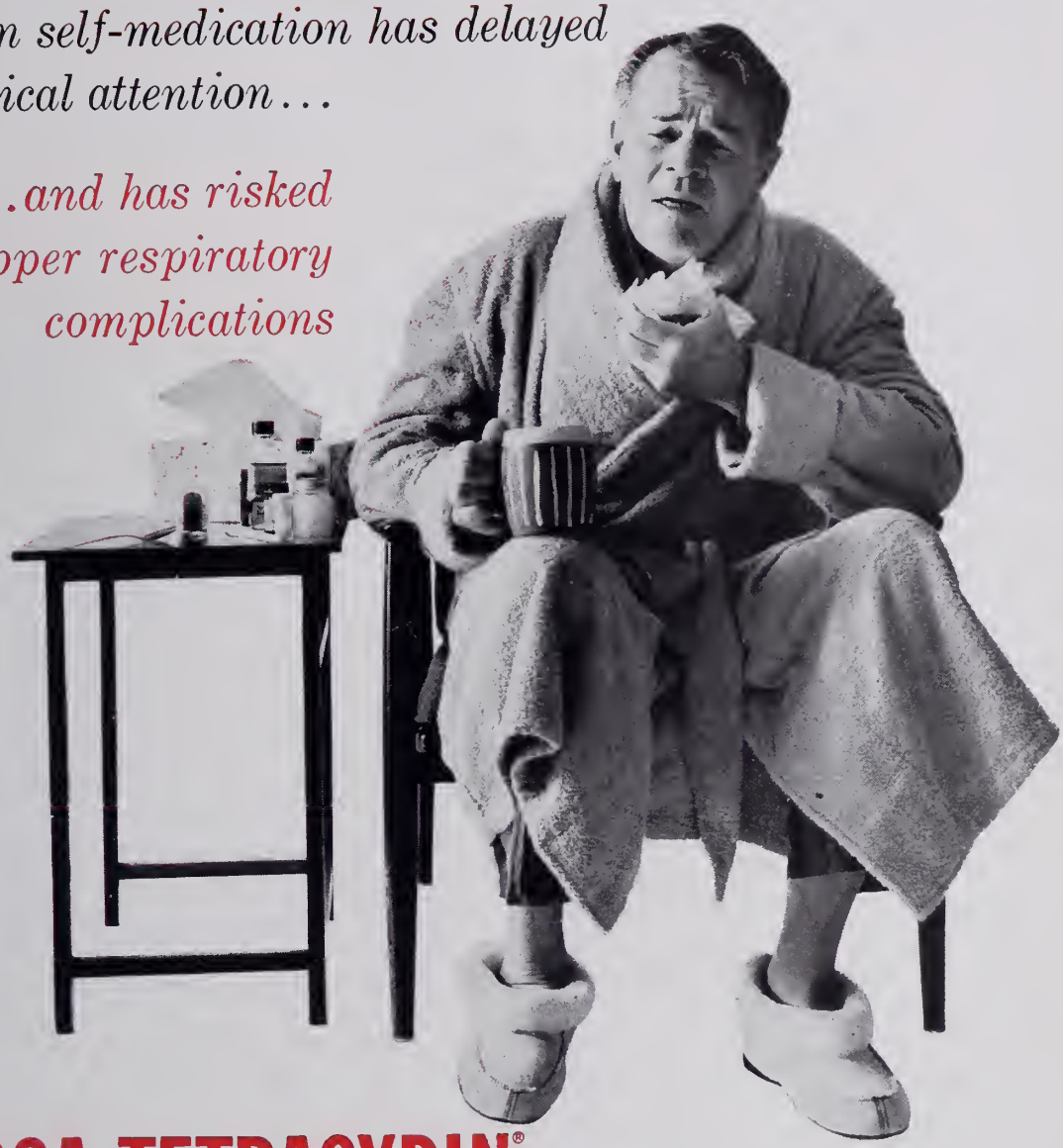
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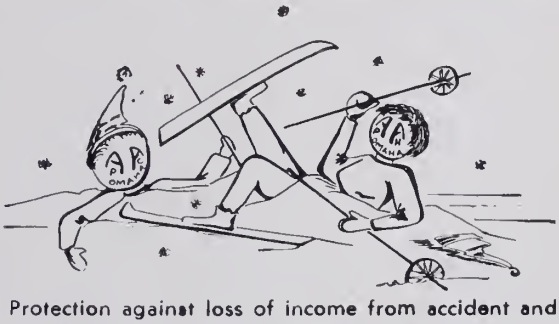
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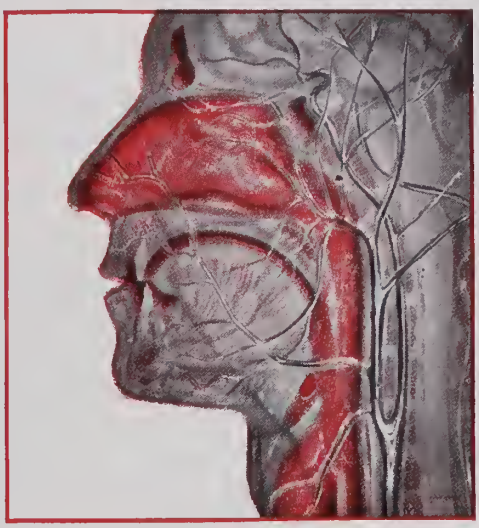
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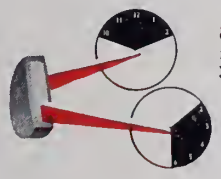
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1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

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1. Gordon, E. E. and Haas, A.: Industrial Medicine & Surgery 28:217, 1959.

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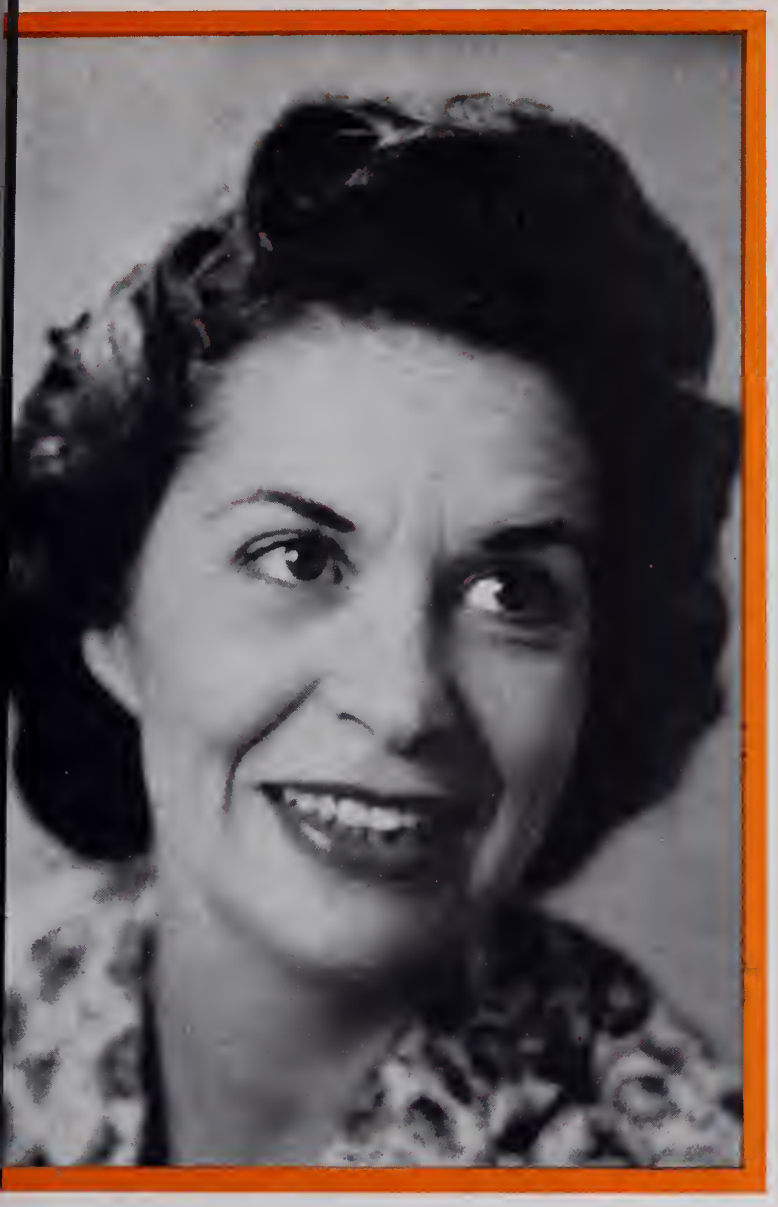
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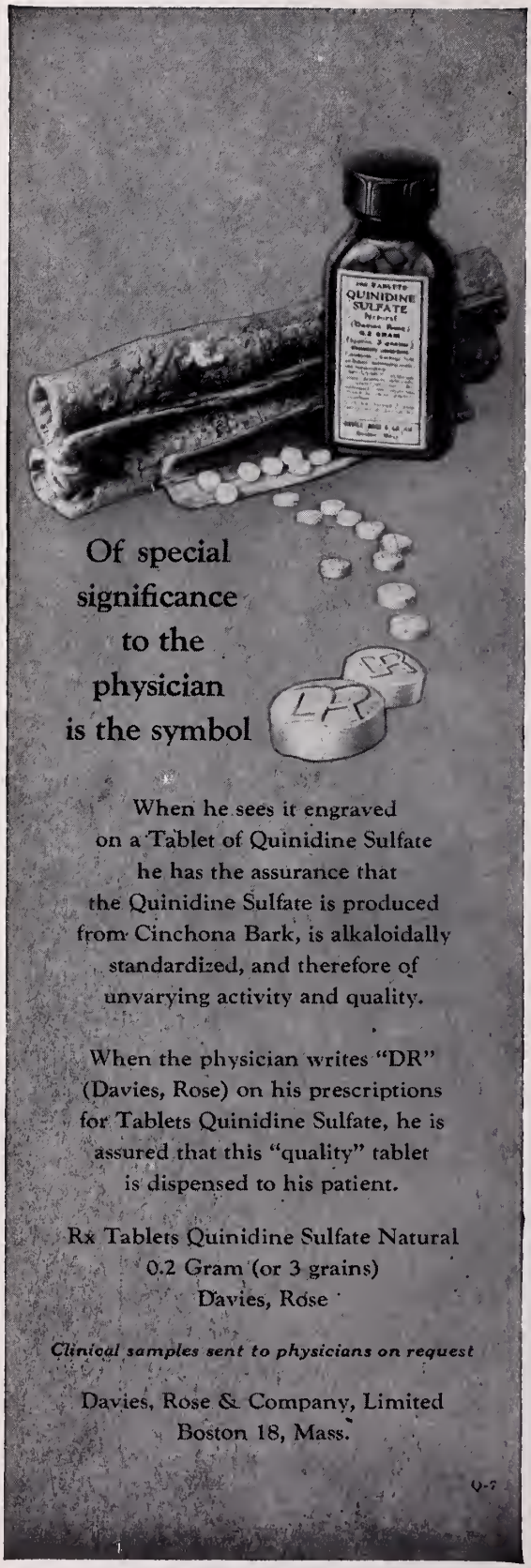
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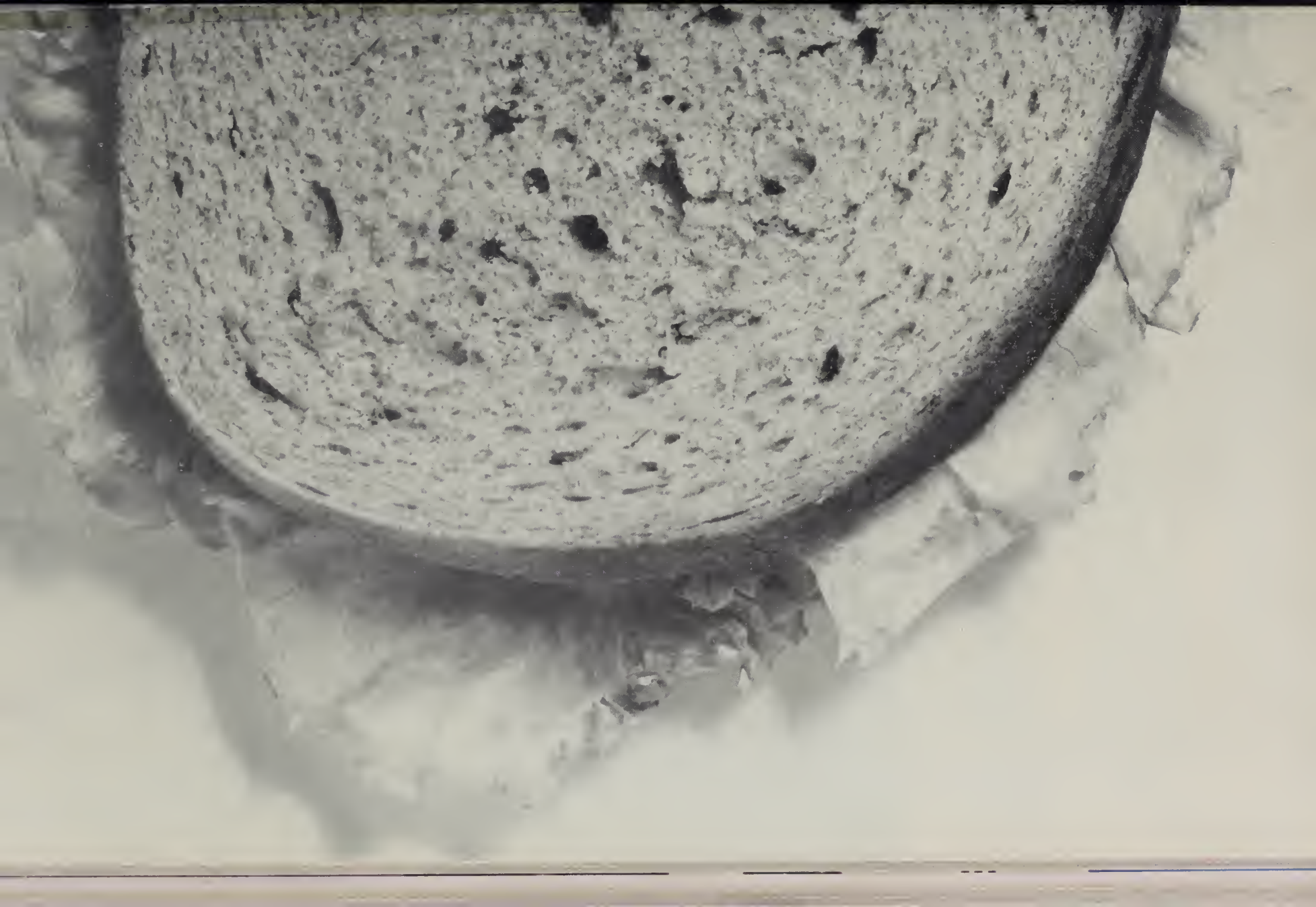
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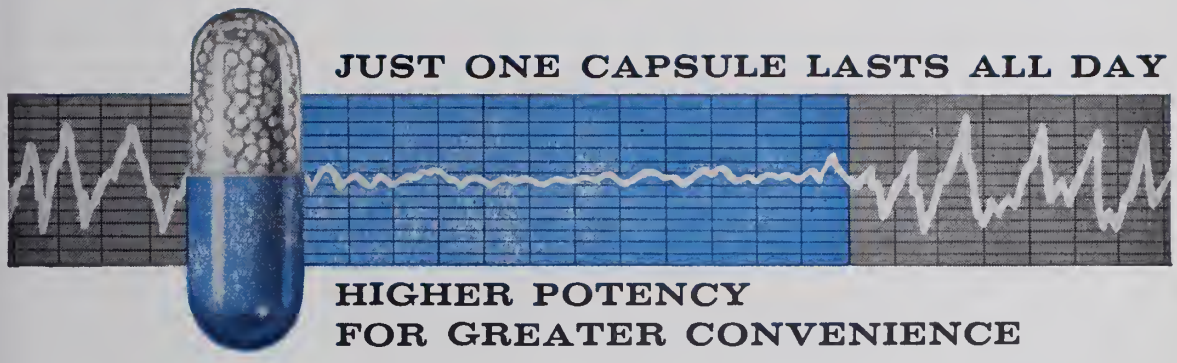
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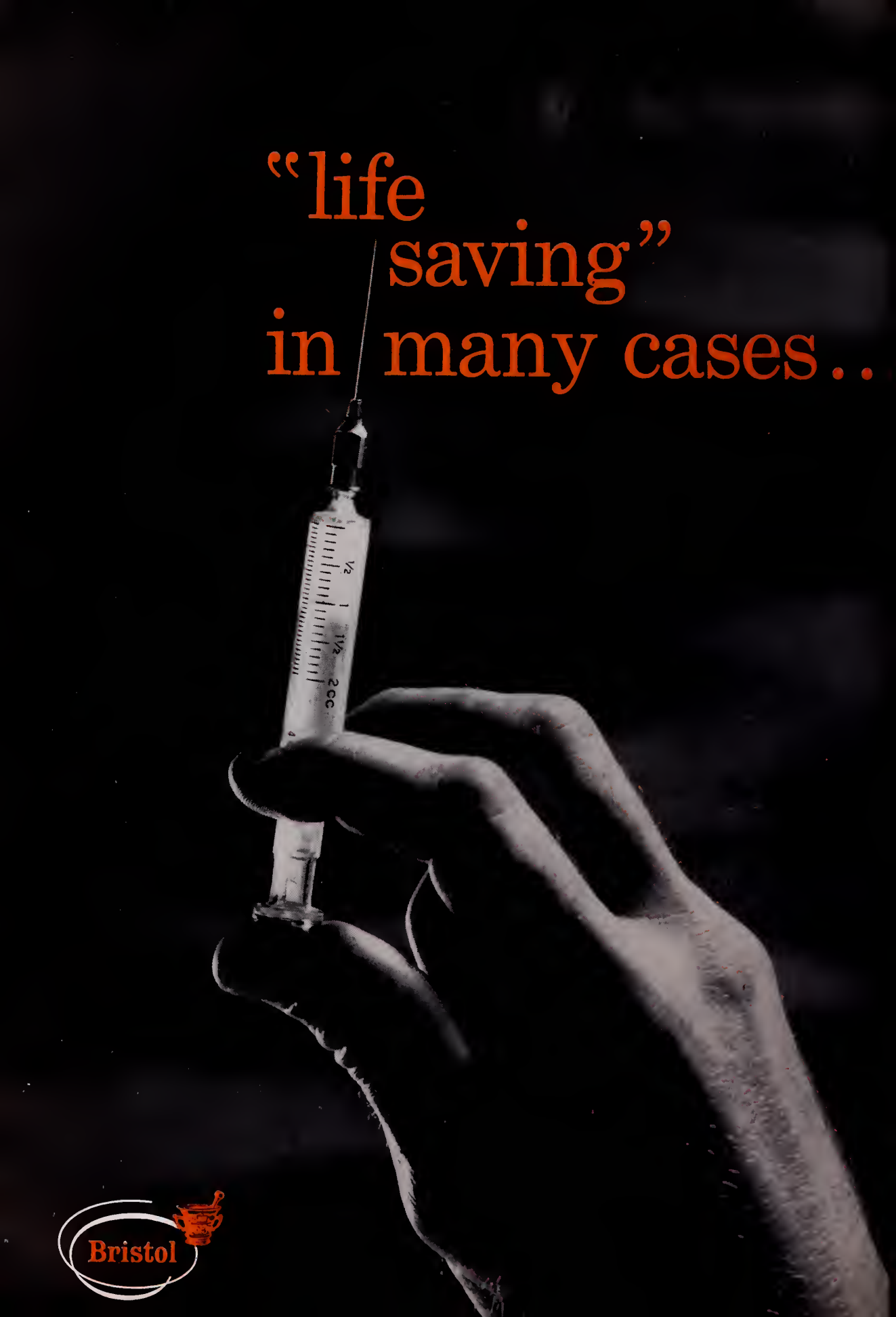
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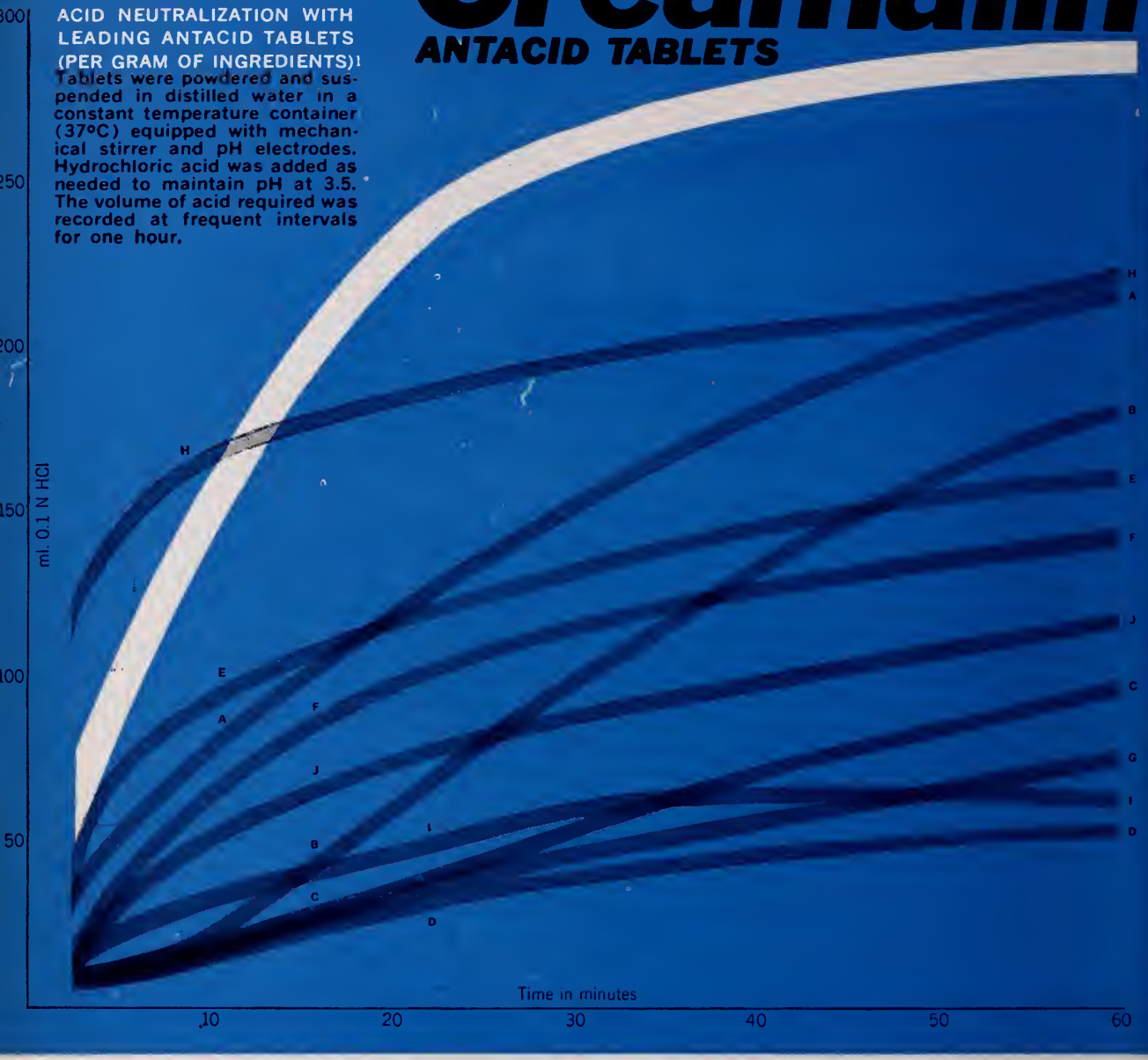
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1. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:380, July, 1959. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:384, July, 1959.

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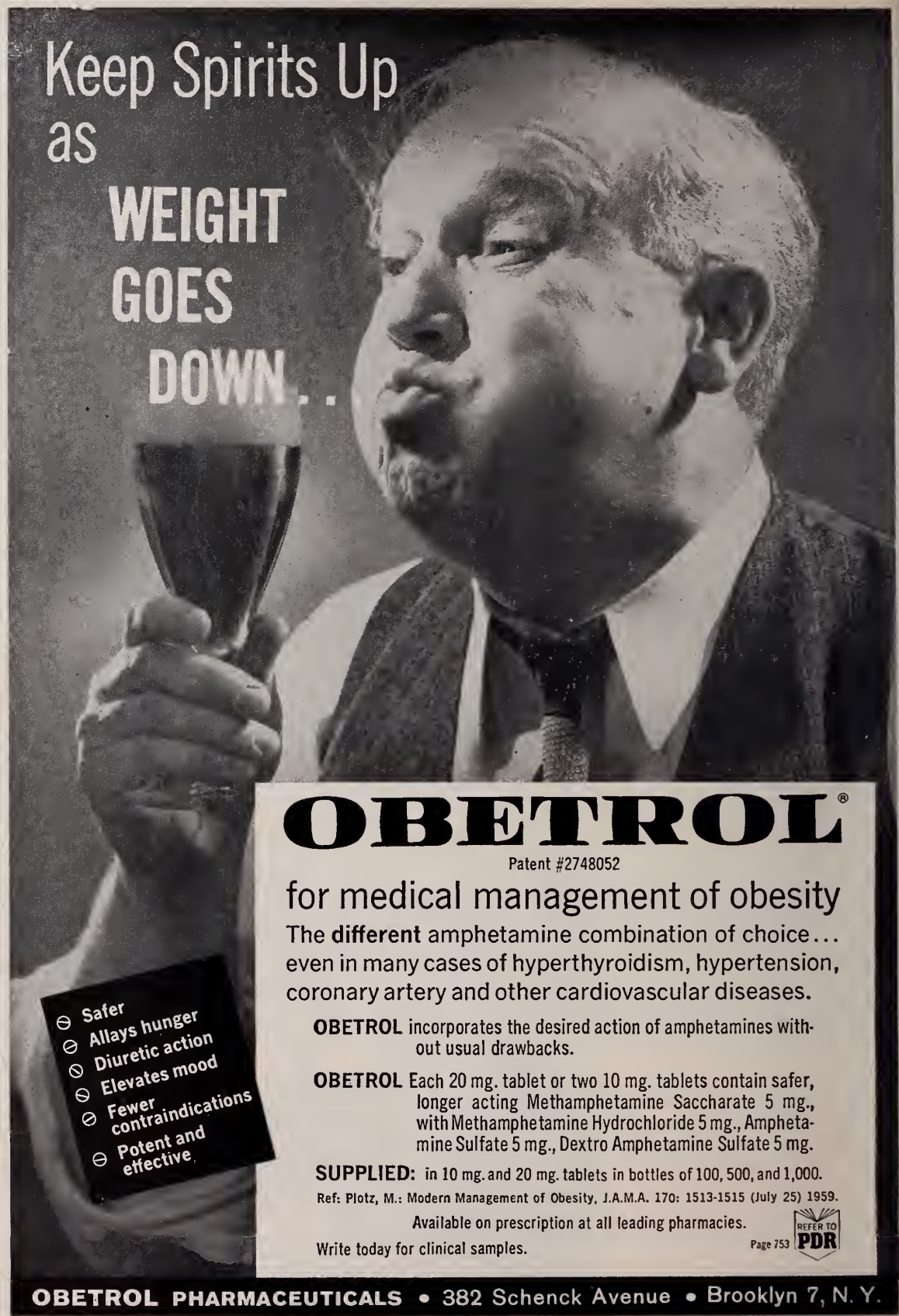
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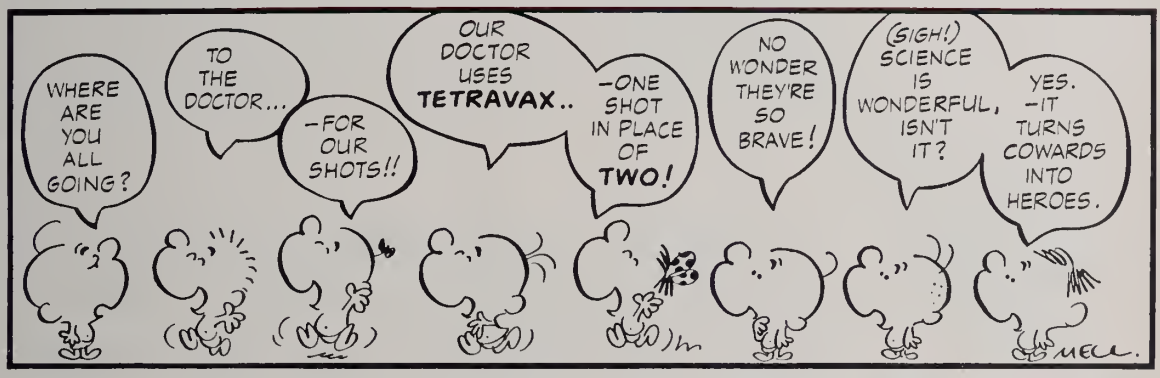
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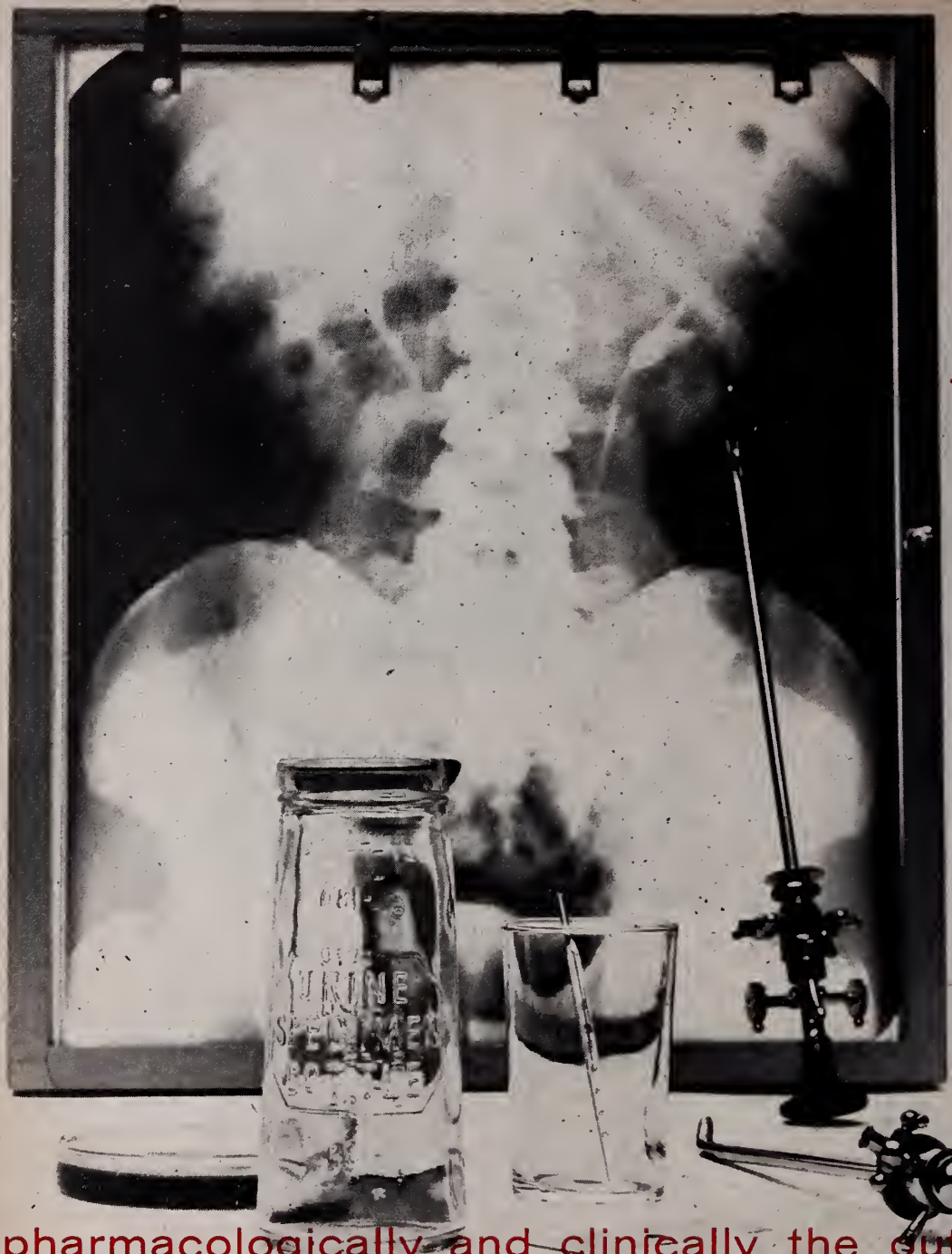
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IN ELDERLY PATIENTS well tolerated by debilitated patients	"... seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. **7**:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. **8**:1584 (Oct.) 1957. Negri, F.: Minerva med. **48**:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics **11**:312 (July) 1956.
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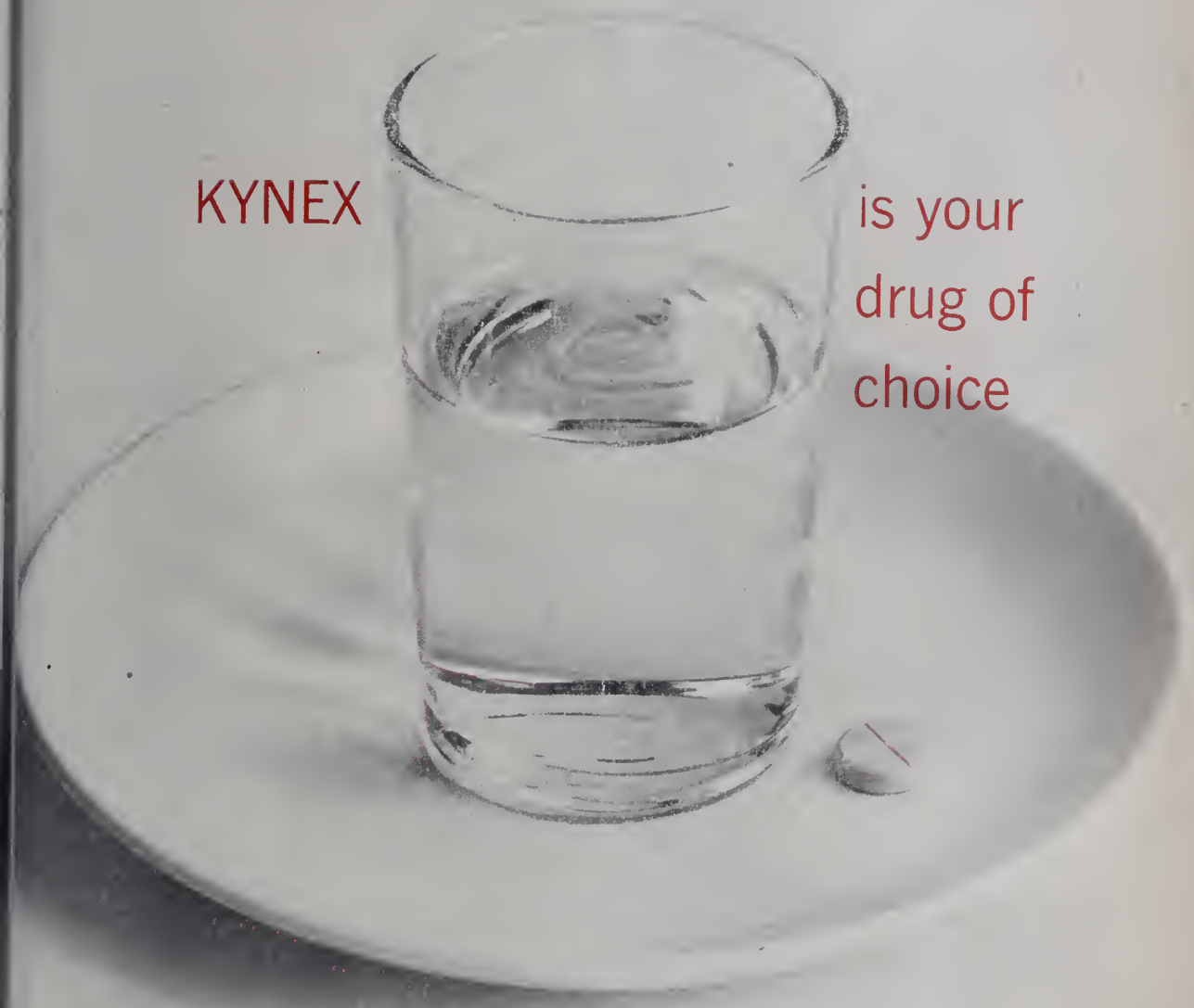
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1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.

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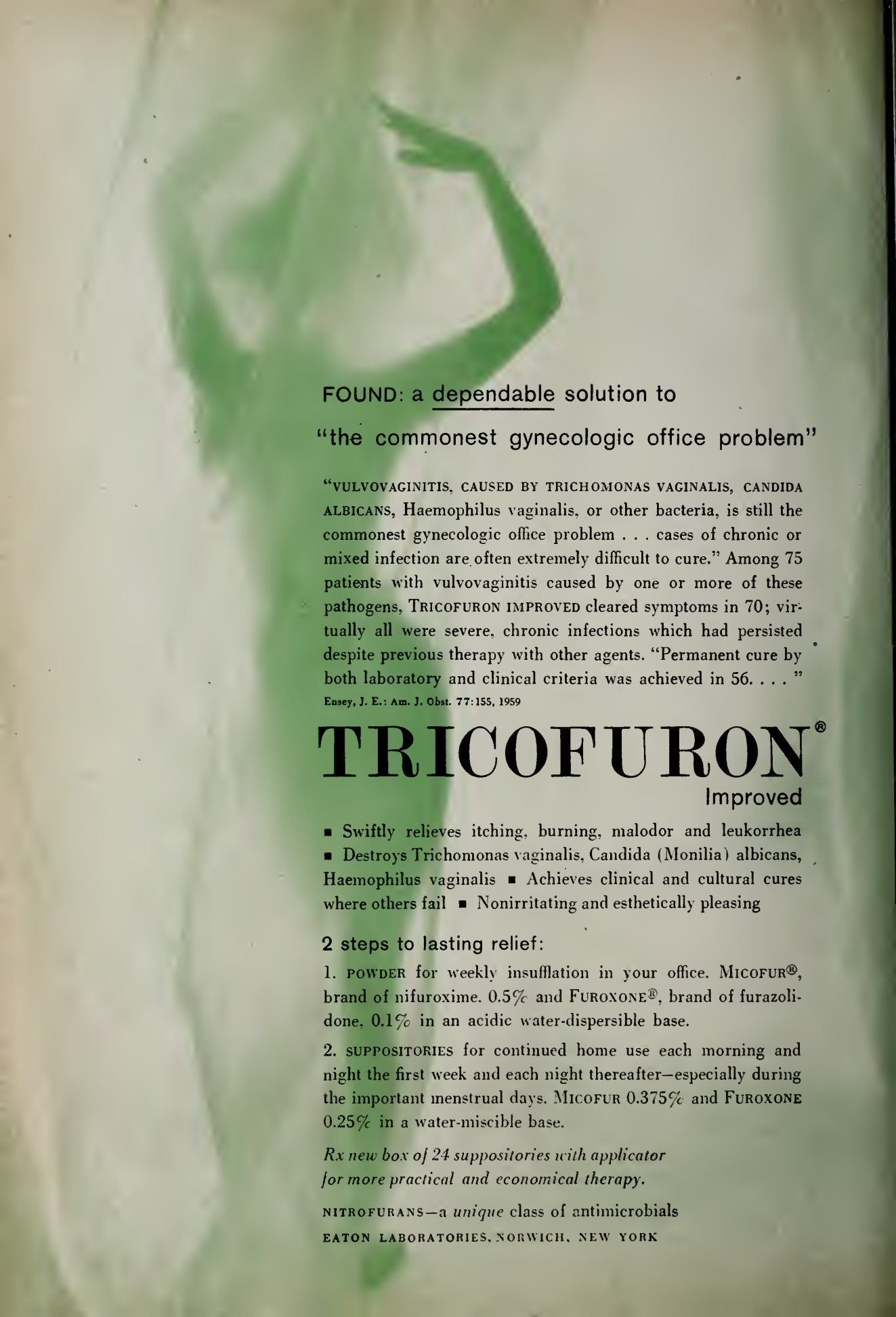
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Ensey, J. E.: Am. J. Obst. 77:155, 1959

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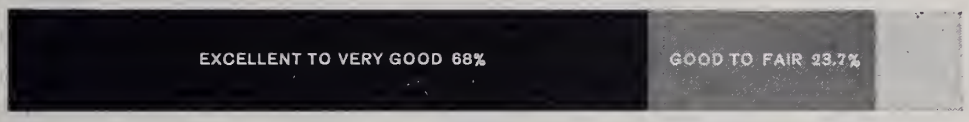
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In 100 consecutive patients with the low back syndrome, Kestler[1] reported that particularly gratifying was the ability of SOMA "to relax muscular spasm, relieve pain, and restore normal movement, thus speeding recovery in a large majority of the patients."

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SUPPLIED—as white, coated, 350 mg. tablets, bottles of 50; also available for pediatric use: 250 mg., orange capsules, bottles of 50

1. Kestler, O.: In The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. 2. Berger, F. M.; Kletzkin, M.; Ludwig, B. J.; Margolin, S., and Powell, L. S.: J. Pharm. Exp. Ther. *127*:66 (Sept.) 1959. 3. Spears, C. E. and Phelps, W. M.: Arch. Pediat. *76*:287 (July) 1959. 4. Phelps, W. M.: Arch. Pediat. *76*:243 (June) 1959. 5. Friedman, A. P.; Frankel, K., and Fransway, R. L.: Papers presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 6. Kuge, T.: Unpublished reports. 7. Ostrowski, J. P.: Orthopedics *2*:7 (Jan.) 1960.

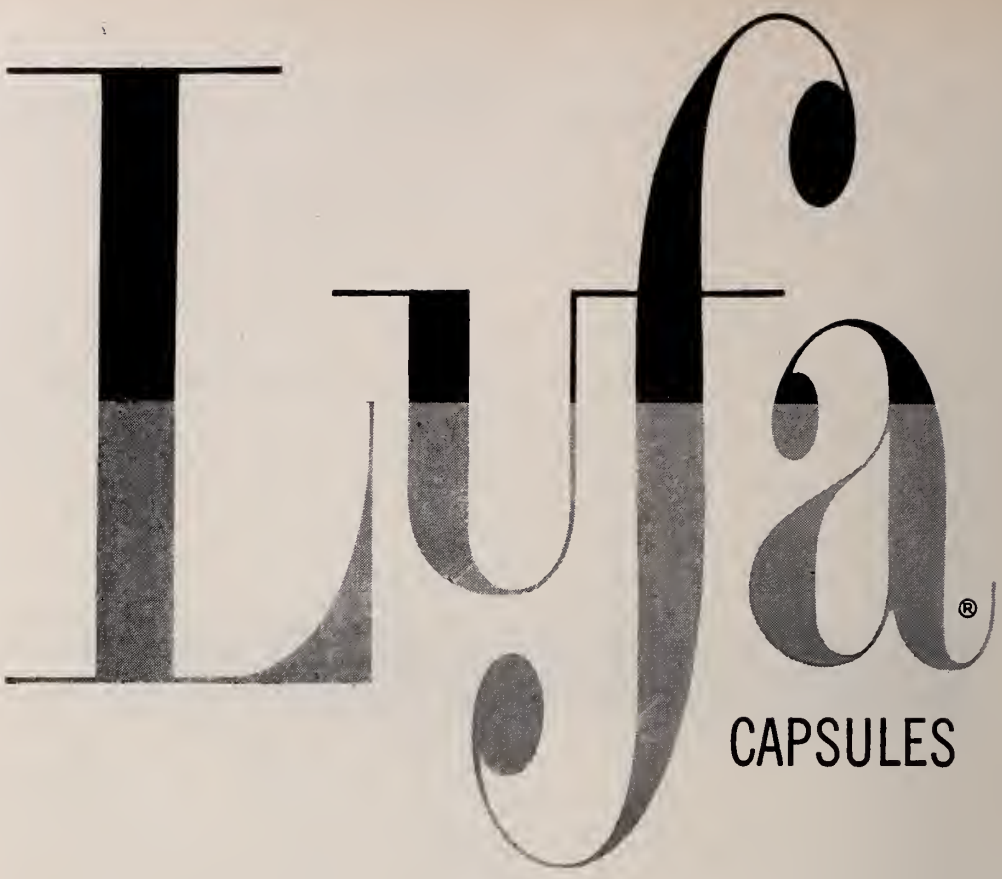
Literature and samples on request

Also available on request: The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. (185 pages)

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Each LUFA capsule provides:

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**from specially refined safflower seed oil.
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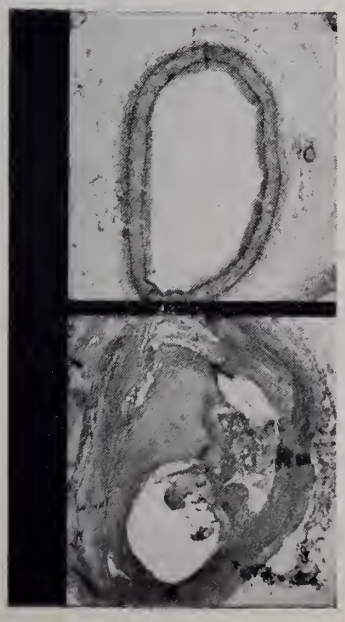
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Q. *When you want to reduce serum cholesterol and maintain it at a low level, is medication more realistic than dietary modifications?*

A. *Maintenance of lowered cholesterol concentration in the blood is a life-long problem. It is usually preferable, therefore, to try to obtain the desired results through simple dietary modification. This spares the patient added expense and permits him meals he will relish.*

The modification is based on a diet to maintain optimum weight plus a judicious substitution of the poly-unsaturated oils for the saturated fats. One very simple part of the change is to cook the selected foods with poly-unsaturated Wesson. In the prescribed diet, this switch in type of fat will help to lower blood serum cholesterol and help maintain it at low levels. The use of Wesson permits a diet planned around many favorite and popular foods. Thus the patient finds it a pleasant, easy matter to adhere to the prescribed course.



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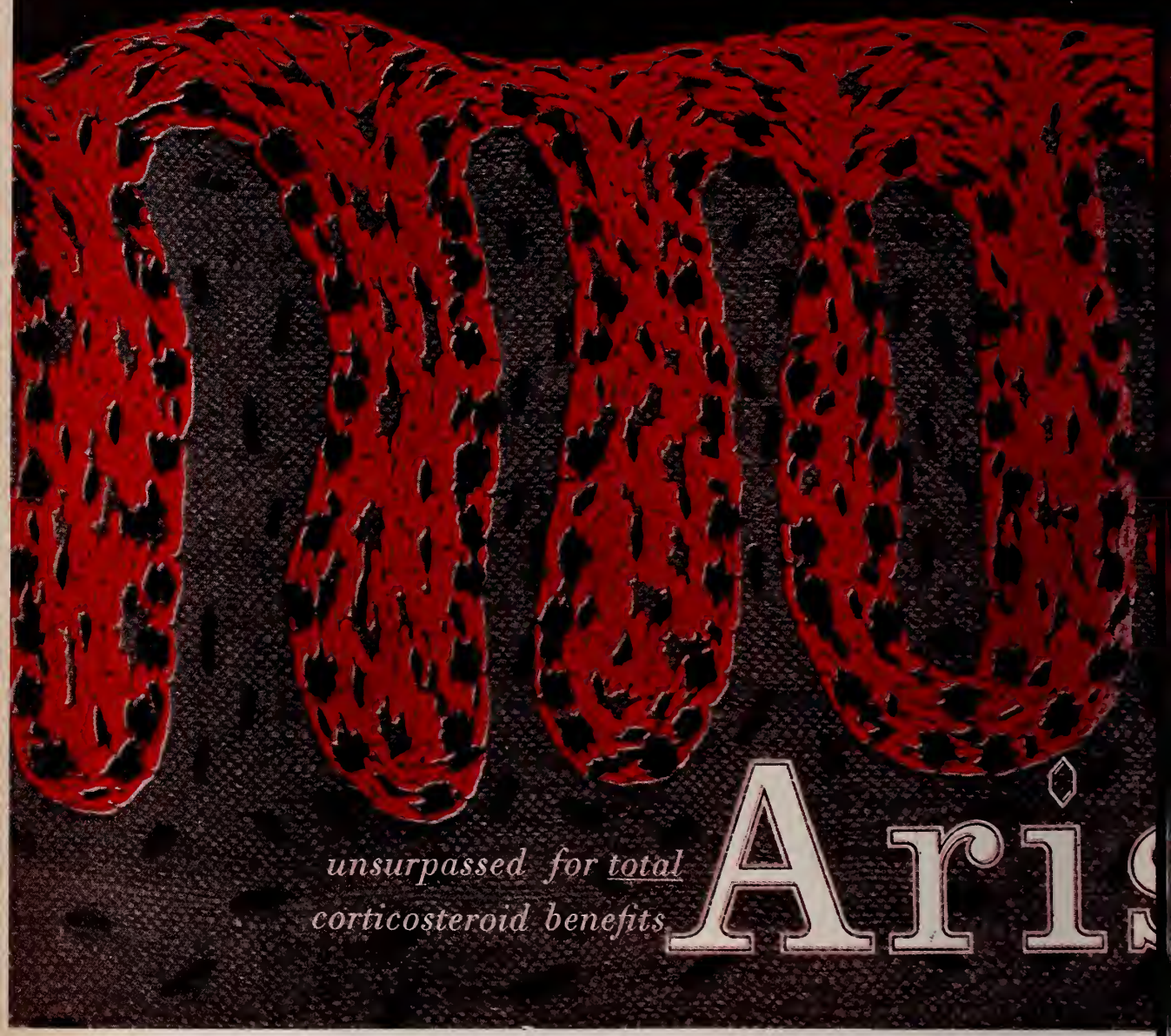
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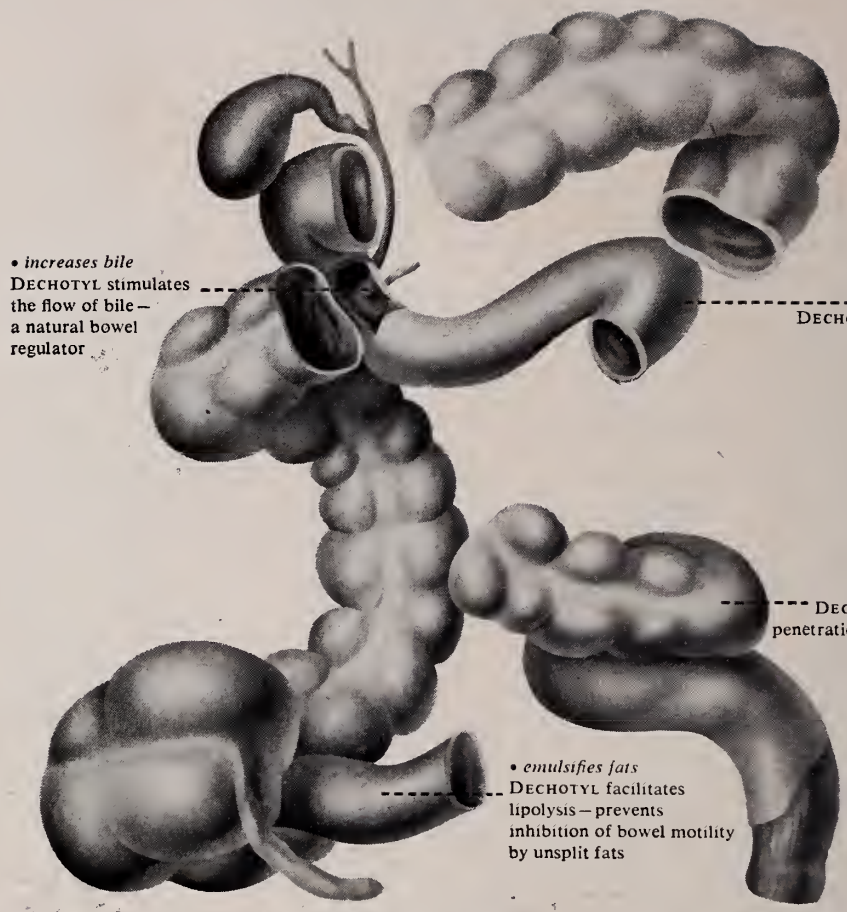
After patients have been on steroids for prolonged periods, discontinuance must be carried out gradually over a period of as much as several weeks.

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References: 1. Feinberg, S. M.; Feinberg, A. R., and Fisherman E. W.: *J.A.M.A.* 167:58 (May 3) 1958. 2. Epstein, J. I., and Sherwood, H.: *Conn. Med.* 22:822 (Dec.) 1958. 3. Friedlaender, S., and Friedlaender, A. S.: *Antibiotic Med. & Clin. Ther.* 5:315 (May) 1958. 4. Segal, M. S., and Duvenci, J.: *Bull. Tufts N.E. Medica Center* 4:71 (April-June) 1958. 5. Segal, M. S.: Report to the A.M.A. Council on Drugs, *J.A.M.A.* 169:1063 (March 7) 1958 6. Hartung, E. F.: *J. Florida Acad. Gen. Practice* 8:18, 1957 7. Rein, C. R.; Fleischwager, R., and Rosenthal, A. L.: *J.A.M.A* 165: 1821 (Dec. 7) 1957. 8. McGavack, T. H.: *Clin. Med.* (June) 1959. 9. Freyberg, R. H.; Berntsen, C. A., and Hellman, L. *Arthritis & Rheumatism* 1:215 (June) 1958. 10. Hartung, E. F. *J.A.M.A.* 167:973 (June 21) 1958. 11. Zuckner, J.; Ramsey, R. H. Caciolo, C., and Gantner, G. E.: *Ann. Rheumat. Dis.* 17:398 (Dec.) 1958. 12. Appel, B.; Tye, M. J., and Leibsohn, E.: *Antibiotic Med & Clin. Ther.* 5:716 (Dec.) 1958. 13. Kulz, F.: *Canad. M.A.J* 79:400 (Sept.) 1958. 14. Mullins, J. F., and Wilson, C. J.: *Texas J Med.* 54:618 (Sept.) 1958. 15. Shelley, W. B.; Harum, J. S., and Pillsbury, D. M.: *J.A.M.A.* 167:959 (June 21) 1958. 16. DuBois E. L.: *J.A.M.A.* 167:1590 (July 26) 1958. 17. McGavack, T. H. Kao, K. T.; Leake, D. A.; Hauer, H. G., and Berger, H. E.: *Am J. M. Sc.* 236:720 (Dec.) 1958. 18. Council on Drugs: *J.A.M.A* 169:257 (January) 1959.

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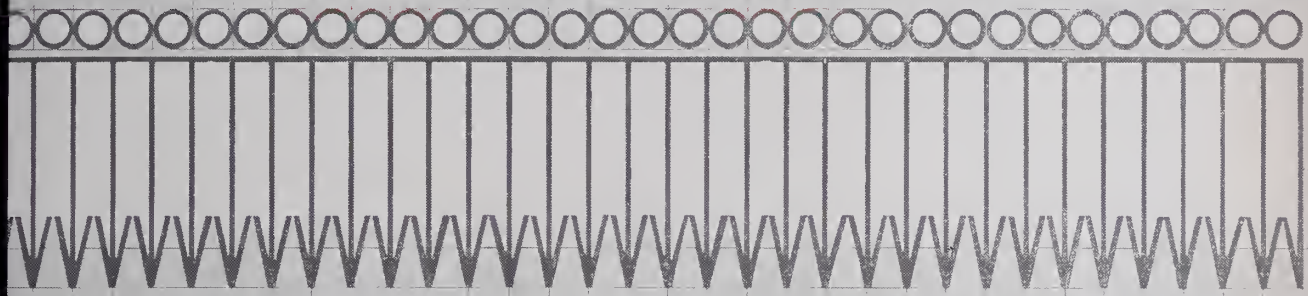
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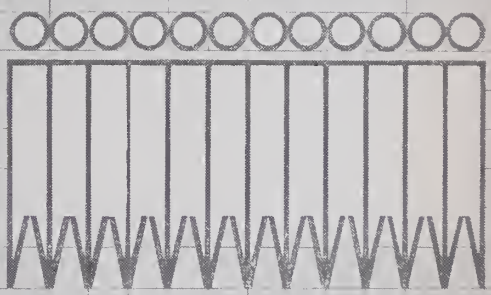
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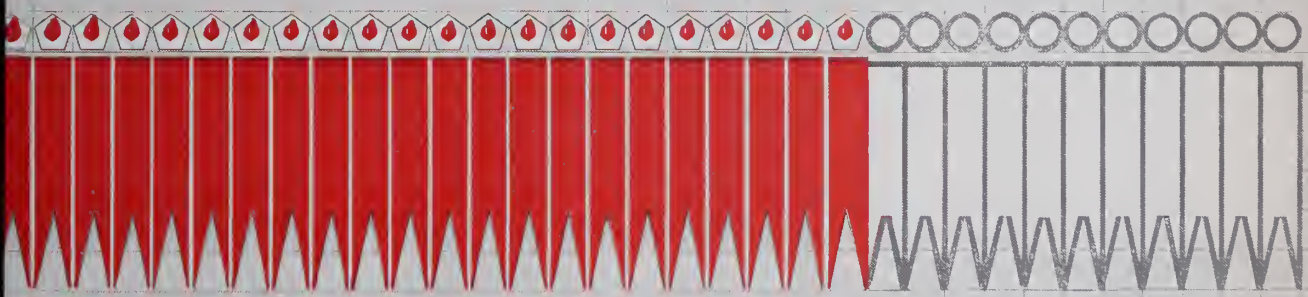
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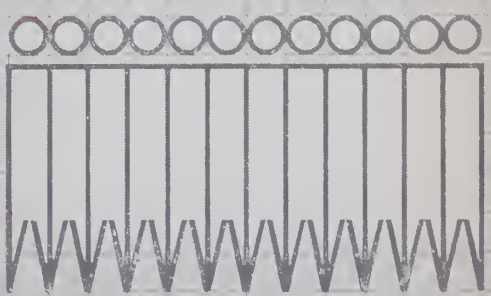


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1. Boland, E. W., and Headley, N. E.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.
2. Bunim, J. J., et al.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.

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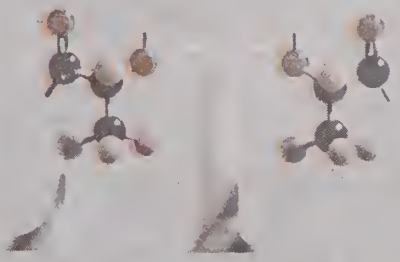
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Significance of complementary action of isomers in SYNCILLIN

The antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than that of either of its two component isomers alone against many important pathogens, including some penicillin-resistant staphylococci. This phenomenon has been described as *Isomeric Complementarity.*

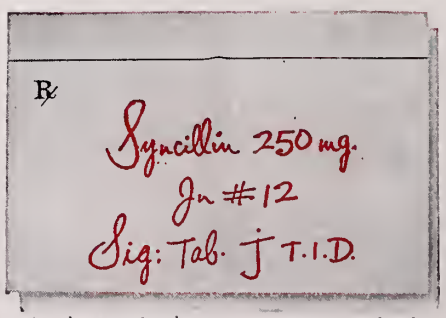
Significance of higher blood levels with SYNCILLIN

Higher blood levels may be of value with organisms of only moderate penicillin sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition, these higher levels may be nccessary where there is infection in areas with a poor blood supply. Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue. Also, antibiotic activity of SYNCILLIN is directly proportional to oral dosage. Increasing the dosage may, therefore, enhance the drug's effectiveness in certain cases.

Efficacy of SYNCILLIN against staphylococci and other resistant organisms

Studies have shown that SYNCILLIN is effective *in vitro* against a higher percentage of hospital "staph" strains, than penicillin G and penicillin V.[1,2] Therefore, if clinical judgment indicates the use of penicillin, SYNCILLIN might be expected to be somewhat more effective. However, since some strains are still resistant to SYNCILLIN as well as to the other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment.

There have recently been reports of decreased efficacy of penicillin in streptococcal[3] and gonococcal[4,5] infections. The emergence of penicillin-resistant gonococci appears to be associated with an increase in the incidence of gonorrhea all over the world. When a less sensitive strain is encountered the higher blood levels produced by SYNCILLIN may be most helpful.



major therapeutic advantages accompany molecular asymmetry

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Relation of intermittent blood levels SYNCILLIN antibacterial efficacy

SYNCILLIN, like all clinically available penicillins, is bactericidal. Periodic high blood concentrations may be sufficient to permit complete eradication of sensitive pathogens. According to Eagle,[6] "Soon after penicillin attains effective concentrations, the bacteria cease multiplying; and the bacteriostatic effect persists for a number of hours after penicillin has fallen to concentrations that are wholly ineffective. . . . The therapeutic significance of this postpenicillin recovery period is enhanced by the fact that the recovering bacteria, damaged but not killed by the previous exposure to penicillin, are abnormally susceptible to the host defenses. In consequence, the bactericidal process *in vivo* continues for many hours after the drug itself has fallen to ineffective concentrations."

Reduced rate of inactivation SYNCILLIN by staph penicillinase

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms. SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers. Further. SYNCILLIN is shown to be more slowly inactivated by this enzyme than penicillin V or penicillin G. Penicillinase from *B. cereus* likewise inactivates SYNCILLIN less rapidly than penicillin V or G.

Indications: SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective *in vitro* against certain strains of staphylococci resistant to other penicillins. SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage: 125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals. Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions: At the present time it is not possible to draw definite conclusions regarding the incidence of allergenicity to SYNCILLIN or its cross-allergenicity with natural penicillins. *Therefore, the usual precautions for oral penicillin therapy should always be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care. Administration of oral penicillin, in rare instances, may provoke acute anaphylaxis, particularly in penicillin-sensitive individuals.

Diarrhea has been reported occasionally following heavy dosage. If this occurs, lengthen the interval between dosages.

If superinfection occurs during therapy, appropriate measures should be taken. Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply: 125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

References: 1. Wright, W. W.: Microbiology Report to Bristol Laboratories Inc. 2. Morigi, E. M. E.; Wheatley, W. B., and Albright, H.: Paper presented at the Seventh Antibiotic Symposium, November 4-6, 1959, Washington, D.C. 3. Editorial: New England J. Med. **261**:305 (Aug. 6) 1959. 4. King, A.: Lancet **1**:651 (March 29) 1958. 5. Epstein, E.: J.A.M.A. **169**:1055 (March 7) 1959. 6. Eagle, H. and Musselman, A. D.: J. Bact. **58**:475, 1949.

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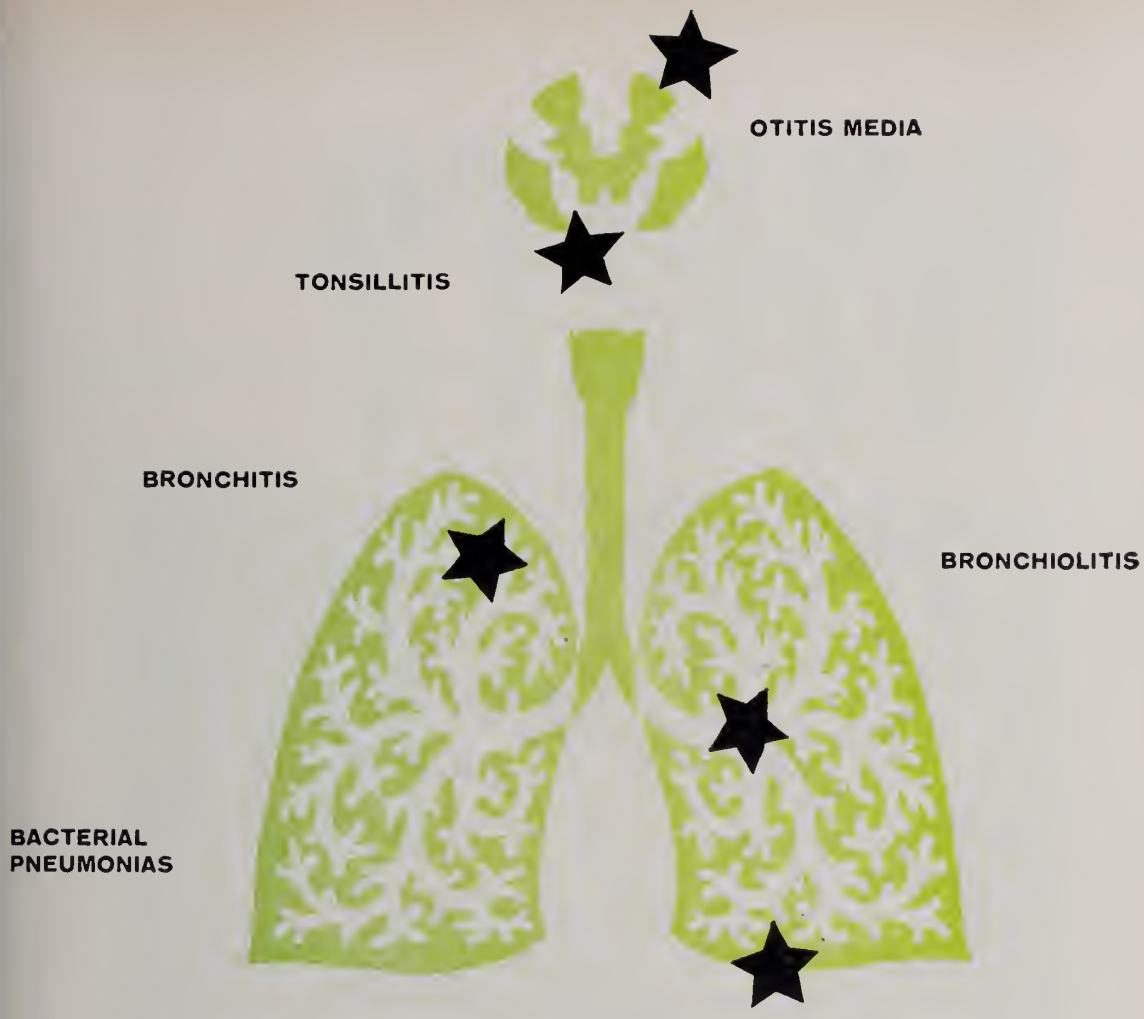
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effective perorally against the majority of common infections caused by pathogenic bacteria including the antibiotic-resistant staphylococci

ALTAFUR is available in tablets of 250 mg. (adult) and 50 mg. (pediatric), bottles of 20 and 100.

1. Lysaught, J. N., and Cleaver, W.: Proceedings of the Detroit Symposium on Antibacterial Therapy (Michigan and Wayne County Academies of General Practice, Detroit, Sept. 12, 1959).

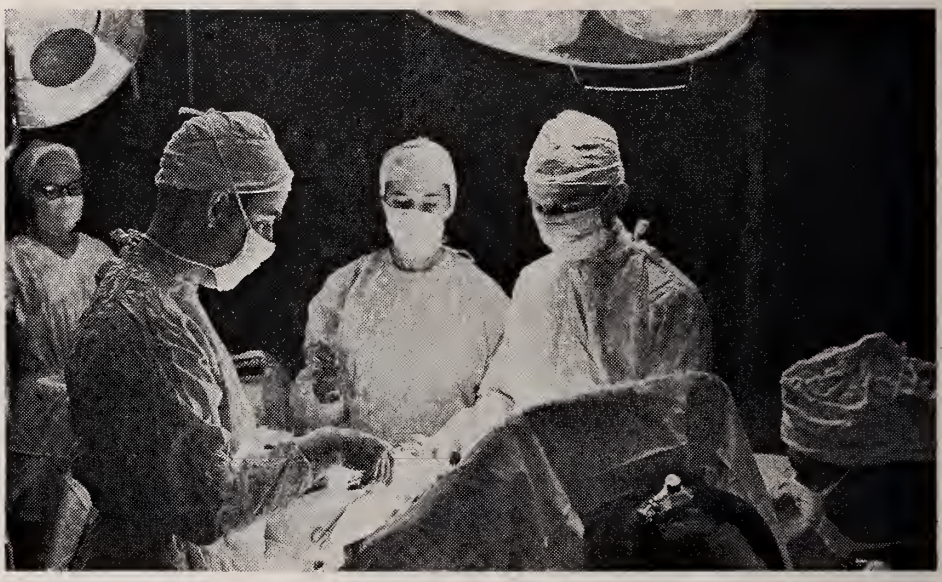
THE NITROFURANS . . . a *unique* class of antimicrobials

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Doctor: One of a series of ads appearing in local newspapers—telling your story to the public.

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When . . . Where . . . Why of Blue Shield

WHAT?



BLUE SHIELD of New Jersey was created in 1942 to help solve a problem that was becoming increasingly serious: *The inability of many people to obtain medical help because they feared they could not afford it.* BLUE SHIELD is based solidly on the idea that the payment of small amounts regularly by a great many people will help cover the necessary doctor bills of subscribers and dependents. The amount the member pays is based on actuarial studies of the number of people who may be expected to obtain medical care, and the extent of that service. *Since 1949,* BLUE SHIELD *has asked for only one raise in its rate to you.* Today, nearly 2,000,000 persons enrolled and more than 6,000 participating physicians out of 8,000 eligible practitioners in New Jersey have a relationship that is not influenced by the individual's ability to pay . . . or complicated by the doctor's difficulty in collecting his fee. Today's BLUE SHIELD is a far cry from the BLUE SHIELD of even a few years ago. Only its basic purpose of *service* to individual and doctor has remained unchanged.

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Only Kent offers this remarkable combination:

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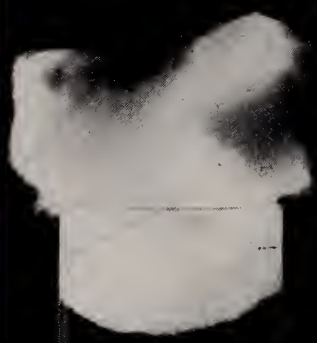
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treats seborrheic dermatitis as an infectious process as well as a cosmetic problem



BETADINE™

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- kills pathogens on contact
- effective adjunctive therapy in severe pyoderma[2]
- safe, nontoxic, nonirritating, nonsensitizing
- rich golden lather, pleasantly scented, leaves hair easy-to-manage

1. Spoor, H.: Proc. Scient. Sec. TGA No. 31, May 1959
2. Frank, L.: New York J. Med. 59:2852, 1959



When blood pressure must come down

When you see symptoms of hypertension such as dizziness, headache, and fainting your patient is a candidate for Serpasil-Apresoline. Even when single-drug therapy fails, Serpasil-Apresoline frequently can bring blood pressure down to near-normal levels, reduce rapid heart rate, allay anxiety.

SUPPLIED: Tablets #2 (standard-strength, scored), each containing 0.2 mg. Serpasil and 50 mg. Apresoline hydrochloride; Tablets #1 (half-strength, scored), each containing 0.1 mg. Serpasil and 25 mg. Apresoline hydrochloride.

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after milk and rest, why Donnalate?

Once you've prescribed milk and rest for a peptic ulcer patient, Donnalate may be the best means for fulfilling his therapeutic regimen. This is because Donnalate combines several recognized agents which effectively complement each other and help promote your basic plan for therapy. A single tablet also simplifies medicine-taking.

in Donnalate: Dihydroxyaluminum aminoacetate affords more consistent neutralization than can diet alone. • Phenobarbital improves the possibility of your patient's resting as you told him to. • Belladonna alkaloids reduce GI spasm and gastric secretion. And by decreasing gastric peristalsis, they enable the antacid to remain in the stomach longer.

Each Donnalate tablet equals one Robalate® tablet plus one-half Donnatal® tablet: Dihydroxyaluminum aminoacetate, N. F., 0.5 Gm.; Phenobarbital (1/8 gr.), 8.1 mg.; Hyoscyamine sulfate, 0.0519 mg.; Atropine sulfate, 0.0097 mg.; Hyoscine hydrobromide, 0.0033 mg.

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A.P.C. WITH DEMEROL® (30 mg.)

1 or 2 tablets three or four times daily.

Considerably more effective than A.P.C. with codeine.

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How Doctors Can Profit From Investments in Giant Real Estate!



by Mortimer L. Schultz, Chairman of Board, Office Buildings of America, Inc., Newark, New Jersey

Mr. Schultz has talked on real estate syndication before hundreds of college, medical, executive and real estate groups throughout the Northeast. The questions presented below are representative of those most often asked by doctors' investment groups and from inquiries received from doctors.

Q What is a Real Estate Syndicate?

A A group of investors who will purchase one particular property together. This property being of a size beyond the means and desire of any one alone.

Q What are current yields and how are they paid?

A Yields currently range from 7 to 14% and because of the nature of real estate syndicates, cash distributions are paid monthly.

Q How can syndicates benefit a doctor?

A Subject to the risks inherent in real estate, participation in syndicates can convert ordinary income into long term capital gain type of income and lessen the investors' tax burden.

Q Show an example of how ordinary income converts to long term capital gains.

A A doctor holding a $110,000 investment in Building Realty Company received $10,450 cash income during 1959. None of this was subject to ordinary income tax and in addition he was permitted to write off an additional $4,700 of income received from his practice due to the depreciation reserves on the particular building.

Q What is the liability of an investing partner?

A A limited partner risks his investment only, and this investment may range from $2,500 up depending on the cost of a unit of participation.

Q Are partnership interests marketable?

A At a price, a willing seller can always find a willing buyer, thus partnership interests are marketable. Many investment firms, such as First Jersey Securities Corporation, have created a secondary market for the resale of syndication units.

Q Who is the typical syndicate investor and how much has been invested in syndicates to date?

A A survey recently taken shows the typical investor to be (a) in his forties or fifties, (b) an executive or professional man with an income of $10,000 to $50,000 and (c) with $5,000 to $35,000 invested in two or more syndicates. Syndicate investments throughout the country are currently at a rate of three billion dollars annually.

Q What is Office Buildings of America, Inc.?

A Office Buildings of America is a realty investment corporation that owns interests in or operates, 30 office buildings and plants throughout the USA. In addition, it is concerned with new construction, lease-backs, mortgage financing, estate planning and the sale of mutual funds. A number of its principals are among the pioneers in real estate syndication.

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Preferably, antibiotic therapy should be based on pretreatment culture of the offending pathogen, but in bacterial pneumonia the problem may well be too pressing to permit the required delay of 24 to 48 hours. A differential diagnosis among bacterial pneumonias, based on such clinical grounds as speed of onset, scpsis and pain may guide the choice of antibiotic for initiation of therapy.

Should clinical judgment dictate that antibiotic therapy be started immediately, at the same time a sputum sample or a subglottic swab can be sent to the laboratory for culture and sensitivity studies. If the response to the first antimicrobial agent proves unsatisfactory, a reasonable basis for changing therapy will then be at hand.

Choosing the Antibiotic

Since therapy must be started at once for bacterial pneumonia, it is advisable to choose a broad-spectrum antibiotic that quickly produces high levels of active agent (e.g., tetracycline phosphate complex, TETREX). Such an antibiotic probably has the best chance of controlling the pathogen, whether it be gram-negative or gram-positive. And if the laboratory report shows that the invading organism is much less sensitive to tetracycline than to other agents, the patient can then be changed to an appropriate antibiotic. If the difference in sensitivity is slight, then the possibility of side effects, sensitization, and toxicity should be evaluated before changing therapy to another antibiotic.

The greatest number of bacterial pneumonias are caused by pneumococci, which respond very well to penicillin, tetracycline, and chloramphenicol. Also, these antibiotics are usually effective against the other gram-positive coccal pneumonias. But penicillin is ineffective against the viral pneumonias and the gram-negative *Hemophilus influenzae* and *Klebsiella pneumoniae*. Although *K. pneumoniae* causes only about 1 to 2 per cent of pneumonia cases on the average,[1] these are apt to be acute and fulminating (Friedländer's pneumonia), with a high mortality rate if not effectively treated. Since pneumococcal pneumonia may be difficult to distinguish clinically from Friedländer's, except by gram-stained sputum smear, it may be wiser to start treatment with an agent also effective against Klebsiella.

Penicillin, however, in addition to having a limited spectrum, also causes many minor and some serious sensitivity reactions. In a recent survey[2] it was found that penicillin produced severe skin reaction. But most important was the observation that anaphylactic shock, with a fatality rate of about 9 per cent, was the most frequent serious reaction. Such severe reactions are almost always associated with parenteral administration.

Tetracycline is also clinically effective in primary atypical pneumonia.[3]

The tetracyclines (e.g., TETREX) have the advantage of a broad range of antimicrobial activity and low toxicity. And in addition, the physician does not have to trouble himself or his patients with repeated blood studies when he prescribes TETREX. Minor reactions such as gastric upsets or mild skin rashes occur occasionally. The most serious side effects are staphylococcal and monilial overgrowth, but these are rare and can be adequately controlled.

No one would deny that appropriate antibiotic therapy has greatly reduced morbidity and saved many lives of patients with bacterial pneumonia. Nevertheless, general supportive measures in the care of patients remain important even today. Especially in the desperately ill patient, antibiotics are not considered as substitutes for the individual evaluation, clinical observation and judgment of the physician.

***Some Micro-organisms Susceptible[a] to Tetracycline* (TETREX)[b]**

Streptococcus; Staphylococcus; Pneumococcus; Gonococcus; Meningococcus; *C. diphtheriae; B. anthracis; E. coli;* Proteus; *A. aerogenes; Ps. aeruginosa; K. pneumoniae;* Shigella; Brucella; *P. tularensis; H. influenzae; T. pallidum;* Rickettsiae; Viruses of psittacosis and ornithosis, lymphogranuloma inguinale, primary atypical pneumonia; *E. histolytica; D. granulomatosis.*

a Some strains are not susceptible.

b Table adapted from Goodman, L. S., and Gilman, A.: The Pharmaceutical Basis of Therapeutics. 2nd edition, New York, The Macmillan Co., 1956, pp. 1322-1323.

References: 1. Wood, W. E., Jr.: In: A Textbook of Medicine. Edited by Cecil, R. L., and Loeb, R. F., 9th edition, Philadelphia, W. B. Saunders Co., 1955, p. 145. 2. Welch, H.; Lewis, C. H.; Weinstein, H. I., and Boeckman, B. B.: Severe reactions to antibiotics. A nationwide survey. Antibiotic Med. & Clin. Ther. 4:800 (Dec.) 1957. 3. Keefer, C. S.: The choice of an anti-infective agent. In: Drugs of Choice, 1958-1959. Edited by Walter Modell, St. Louis, The C. V. Mosby Co., 1958, p. 135.

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PRINCETON HOSPITAL'S modern approach to long-term nursing care

Merwick, the Elsie Procter Matthews Unit of Princeton Hospital, is a pioneer medical undertaking in the state of New Jersey. Designed specifically for geriatric cases and the chronically ill of all ages (except pediatric cases), it is the first long-term nursing facility in the State directly operated by a general hospital.

The chief purpose of Merwick is to provide an attractive home, complete with all the facilities which make up a well-rounded life within the physical limitations of its guests, while adding the important factors of skilled medical supervision and nursing care.

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Squibb Alpha-Phenoxyethyl Penicillin Potassium

new chemically improved penicillin which provides the highest blood levels that are obtainable with oral penicillin therapy



As a pioneer and leader in penicillin therapy for more than a decade, Squibb is pleased to make Chemipen, a new chemically improved oral penicillin, available for clinical use.

With Chemipen it becomes possible as well as convenient for the physician to achieve and maintain higher blood levels—with greater speed—than those produced with comparable therapeutic doses of potassium penicillin V. In fact, Chemipen is shown to have a 2:1 superiority in producing peak blood levels over potassium penicillin V.*

Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 tablets. Chemipen Syrup (cherry-mint flavored, nonalcoholic), 125 mg. per 5 cc., 60 cc. bottles.

*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

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Steiner, L., Webb, C., and Adriani, J.: The Preoperative Sedation of Children, Presented before the Southern Society of Anesthesiologists, Annual Meeting, April 23-25, 1959, Birmingham, Alabama.

Oral Suspension—25 mg. per 5 cc. teaspoonful. *Capsules*—25, 50 and 100 mg. *Parenteral Solution* (as the HCl)—25 mg. per cc., 10 cc. vials and 2 cc. Steraject® Cartridges; 50 mg. per cc., 2 cc. ampules.

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Lifts depression..



You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in two or three days.* She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

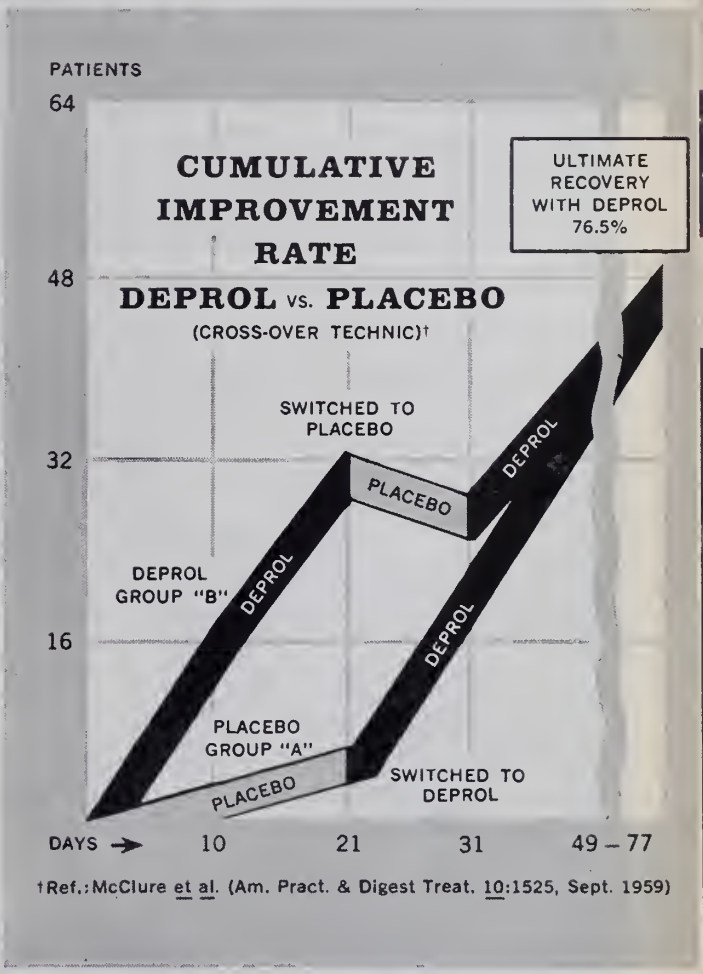
Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient – *they often aggravate anxiety and tension.* And although amphetamine-barbiturate combinations may counteract excessive stimulation – *they often deepen depression.*

In contrast to such "seesaw" effects, Deprol lifts depression as it calms anxiety – both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within two or three days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within two or three days.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function – frequently reported with other antidepressant drugs.



†Ref.: McClure et al. (Am. Pract. & Digest Treat. 10:1525, Sept. 1959)

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1. Alexander, L. (35 potients): Chemotherapy of depression – Use of meprobomote combined with benactyzine (2-diethylominoethyl benzilote) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Batemon, J. C. ond Carlton, H. N. (50 potients): Meprobomote and benactyzine hydrochloride (Deprol) os adjunctive therapy for patients with advonced concer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 potients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **4.** Breitner, C. (31 potients): On mentol depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **5.** Londmon, M. E. (50 potients): Choosing the right drug for the potient. Submitted for publicotion, 1960. **6.** McClure, C. W., Popas, P. N., Speore, G. S., Polmer, E., Slottery, J. J., Kanefal, S. H., Henken, 8. S., Wood, C. A. ond Ceresia, G. B. (128 potients): Treotment of depression–New technics ond therapy. Am. Proct. & Digest Treat. 10:1525, Sept. 1959. **7.** Pennington, V. M. (135 potients): Meprobomote-benactyzine (Deprol) in the treotment of chronic broin syndrome, schizophrenio and senility. J. Am. Geriotrics Soc. 7:656, Aug. 1959. **8.** Rickels, K. ond Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **9.** Ruchworger, A. (87 potients): Use of Depral (meprobomote combined with benoctyzine hydrochloride) in the office treotment of depression. M. Ann. District of Columbio 28:438, Aug. 1959. **10.** Settel, E. (52 potients): Treotment of depression in the elderly with o meprobamate-benoctyzine hydrochloride combinotion (Depral). Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **11.** Splitter, S. R. (84 patients): The core of the anxious and the depressed. Submitted for publicotion, 1959.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

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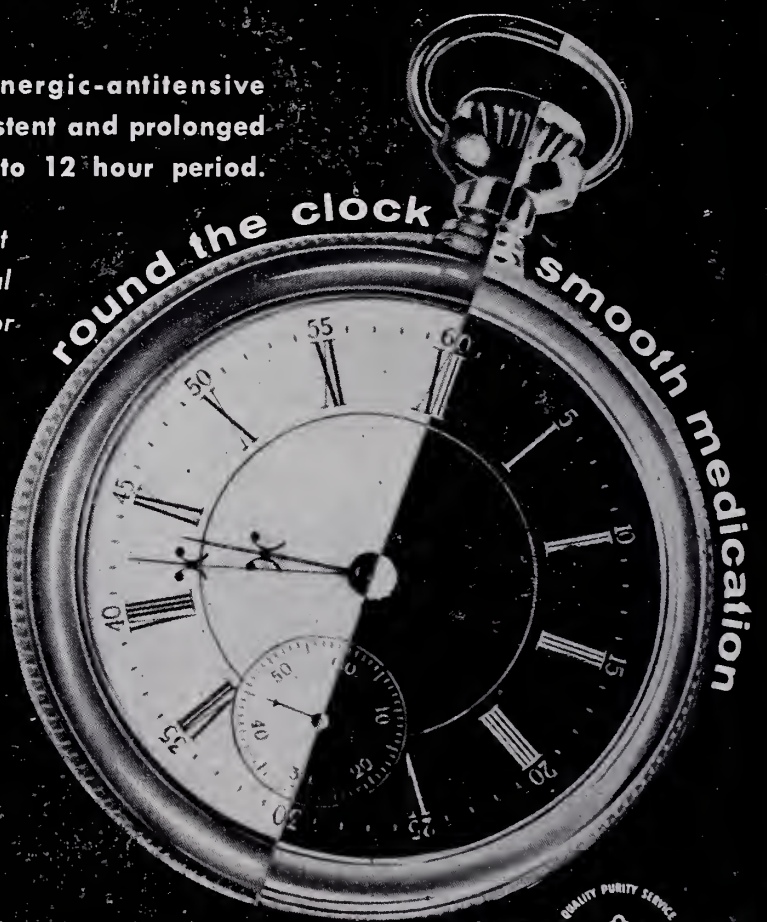
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The rate of release is independent of location in the gastrointestinal system—the same rate in ***ACID*** *or* ***ALKALINE*** *media.*



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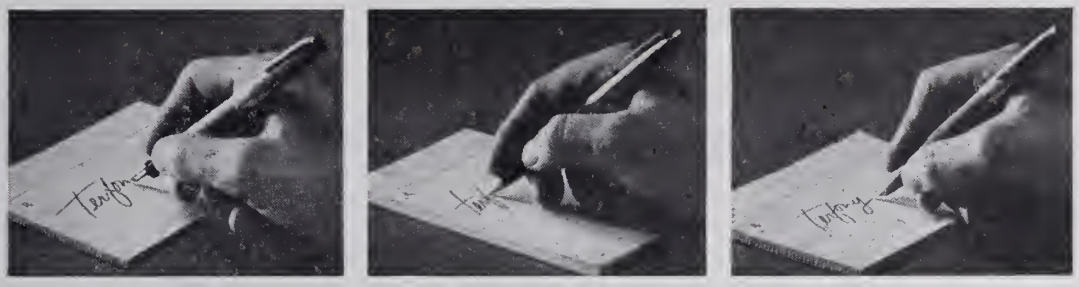
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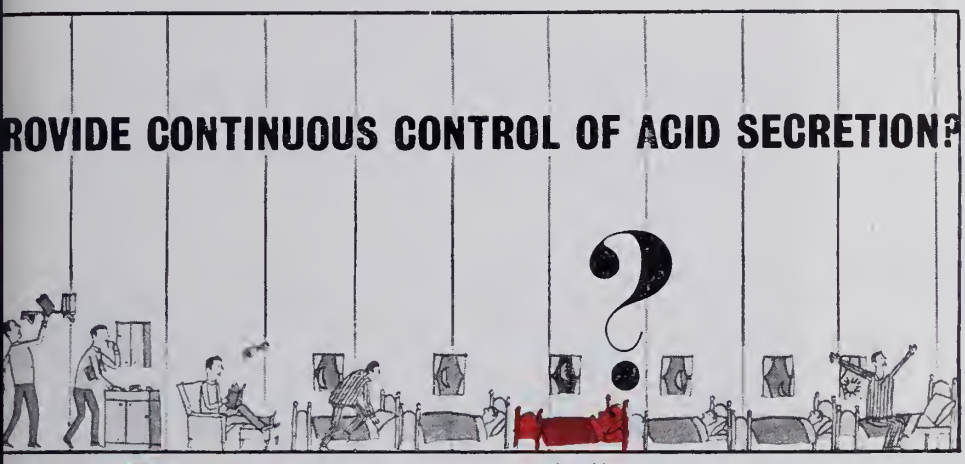
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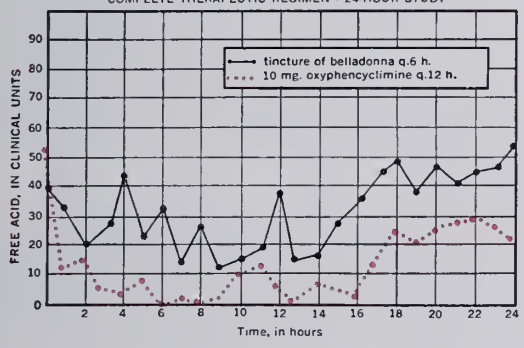
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As for Safety: "Side reactions were uncommon, usually no more than dryness of the mouth...."[4]

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Supplied: In bottles of 60 black-and-white scored tablets.

References: 1. McHardy, G., et al.: J. Louisiana M. Soc. 111:290 (Aug.) 1959. 2. Steigmann, F.: Study conducted at Cook County Hospital, Chicago, Illinois, in press. 3. Kemp, J. A.: Antibiotic Med. & Clin. Therapy 6:534 (Sept.) 1959. 4. Leming, B. H., Jr.: Clin. Med. 6:423 (Mar.) 1959. 5. Data in Roerig Medical Department files.

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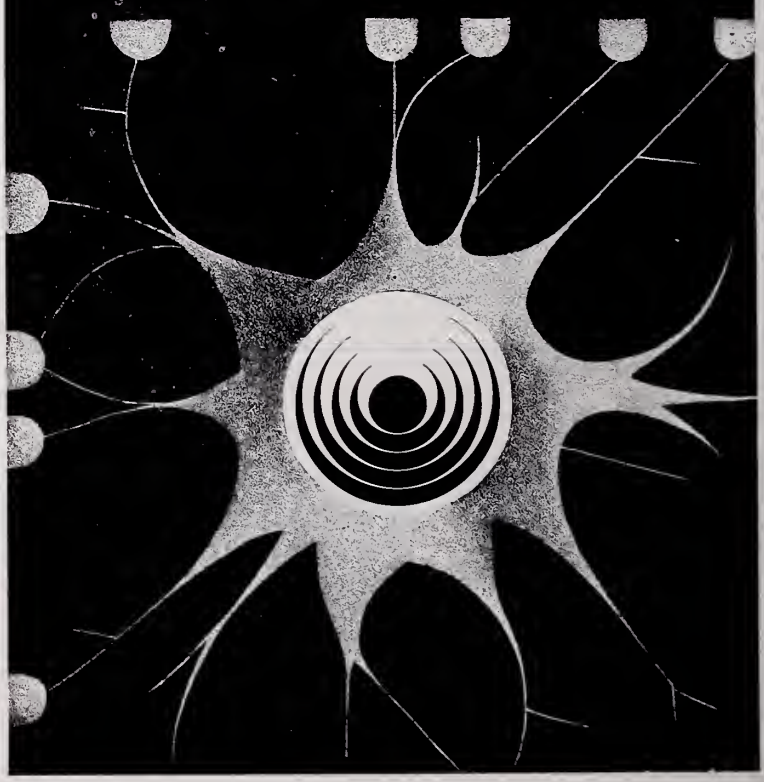
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a potent thymoleptic . . .
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References: 1. Ayd, F. J., Jr.: Bull. School Med., Univ. Maryland *44*:29, 1959. 2. Azima, H., and Vispo, R. H.: A.M.A. Arch. Neurol. & Psychiat. *81*:658, 1959. 3. Lehmann, H. E.; Cahn, C. H., and de Verteuil, R. L.: Canad. Psychiat. A. J. *3*:155, 1958. 4. Mann, A. M. and MacPherson, A. S.: Canad. Psychiat. A. J. *4*:38, 1959. 5. Sloane, R. B.; Habib, A., and Batt, U. E.: Canad. M.A.J. *80*:540, 1959. 6. Straker, M.: Canad. M.A.J. *80*:546, 1959. 7. Strauss, H.: New York J. Med. *59*:2906, 1959.

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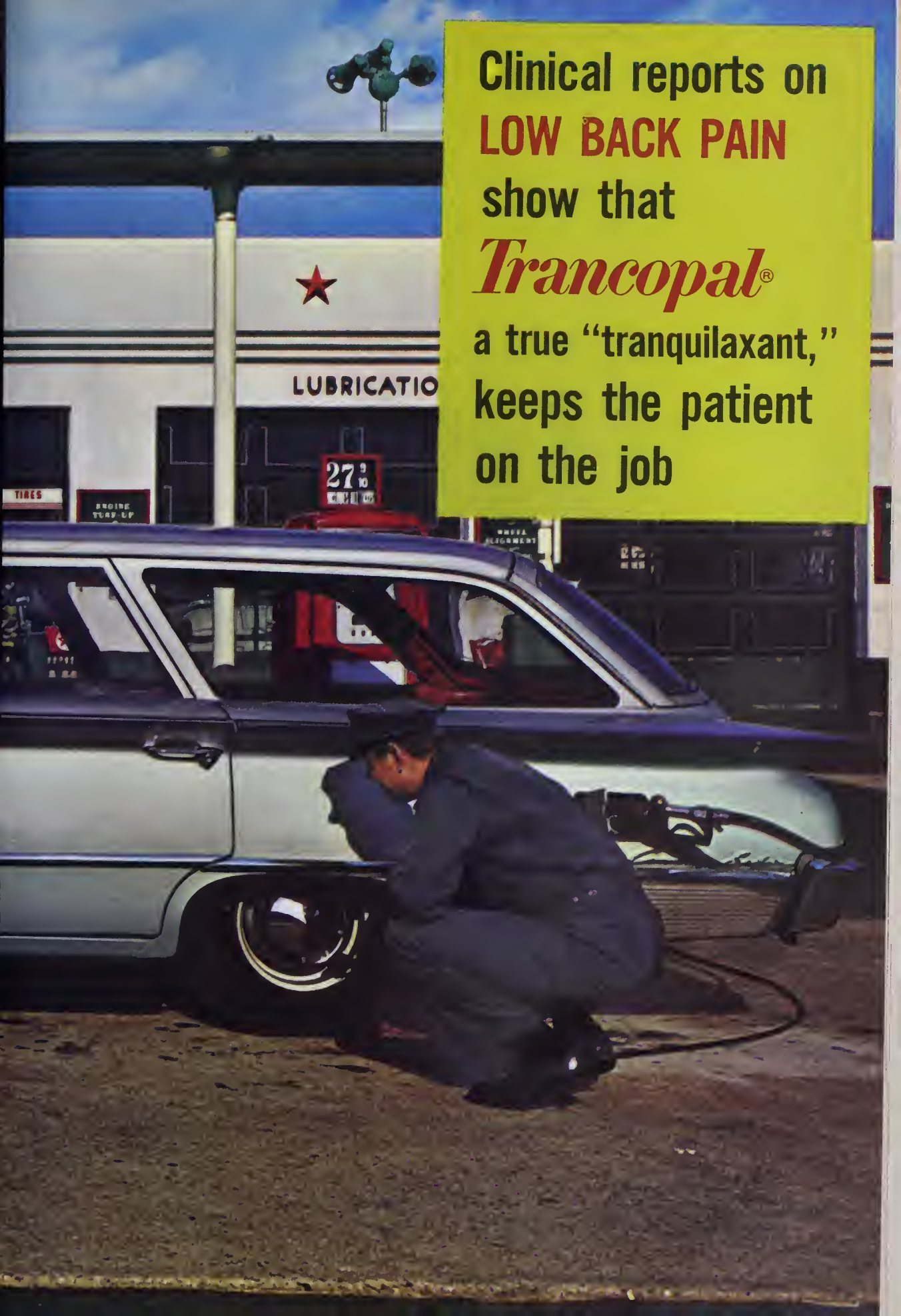
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References: 1. Lichtman, A. L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958. 2. Mullin, W. G., and Epifano, Leonard: Am. Pract. & Digest Treat. 10:1743, Oct., 1959. 3. Gruenberg, Friedrich: Current Therap. Res. 2:1, Jan., 1960. 4. Shanaphy, J. F.: Current Therap. Res. 1:59, Oct., 1959. 5. Ganz, S. E.: J. Indiana M. A. 52:1134, July, 1959. 6. Stough, A. R.: J. Oklahoma M. A. 52:575, Sept., 1959.

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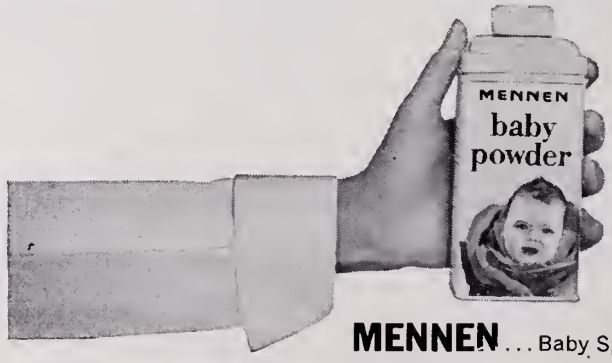
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Winkelstein, A.: Am. J. Gastroenterol. *32*:66-70 (July) 1959.

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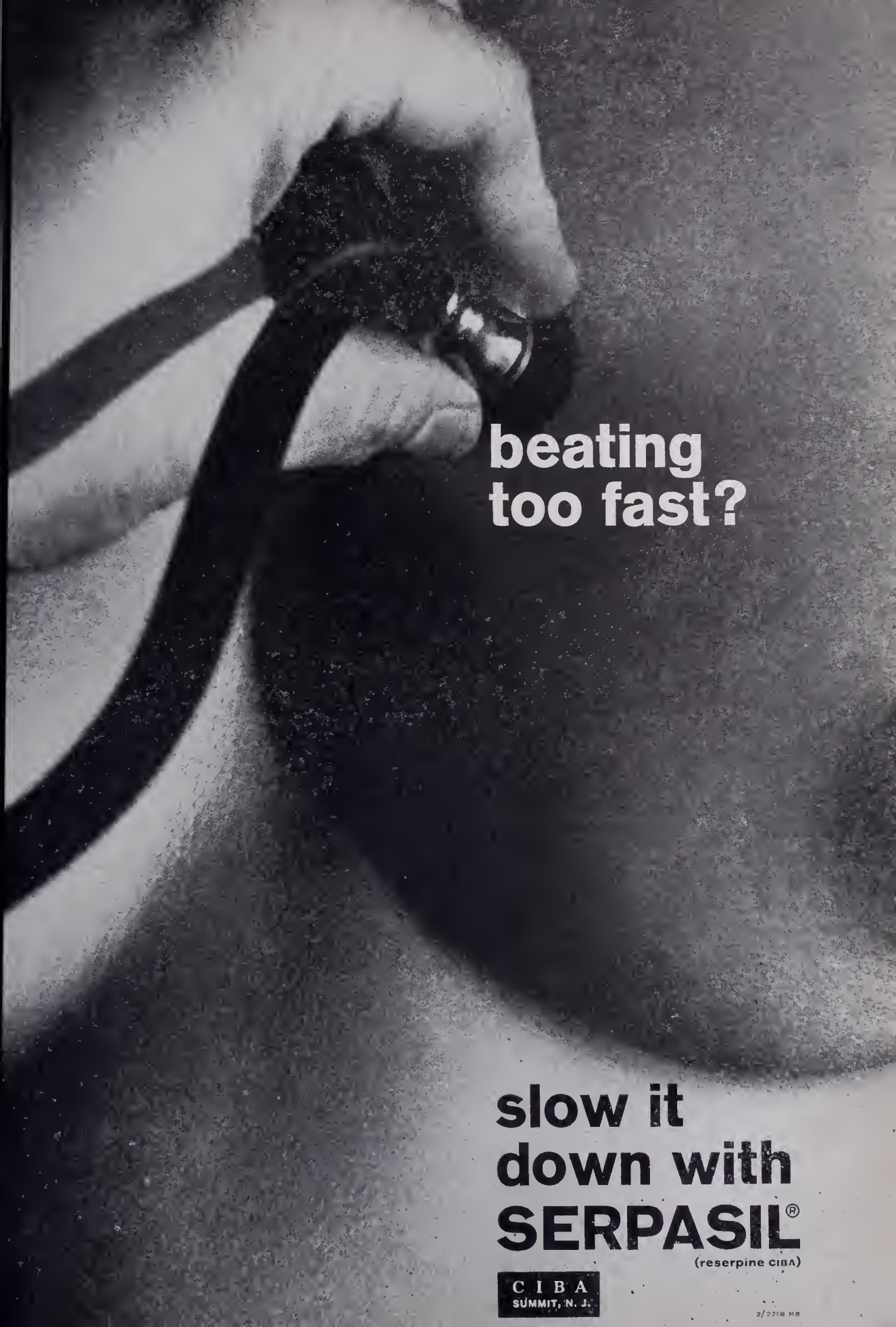
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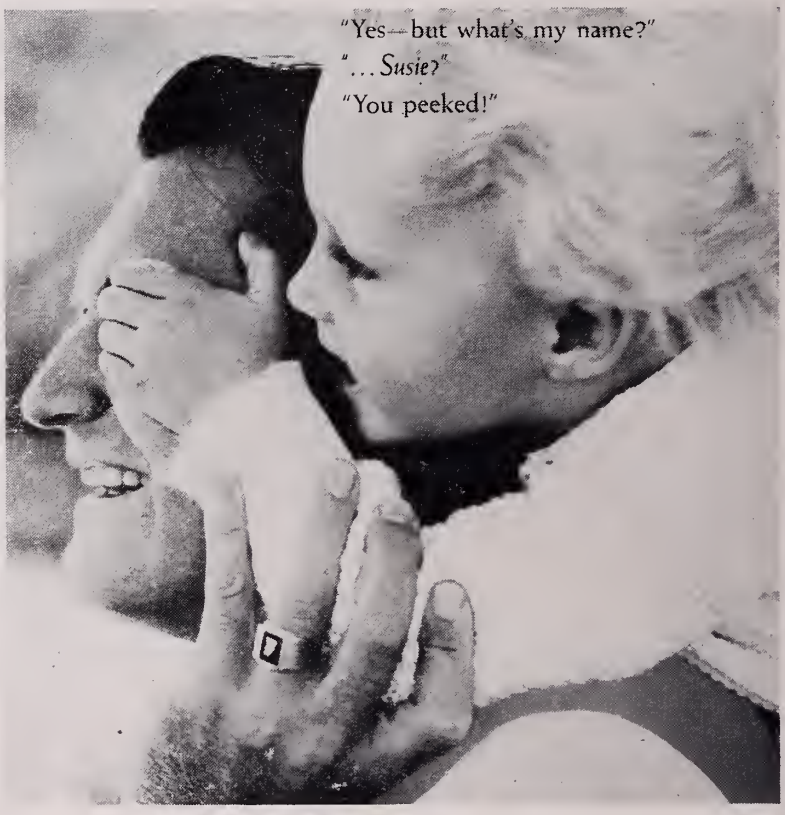
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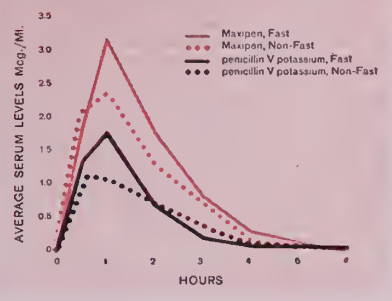
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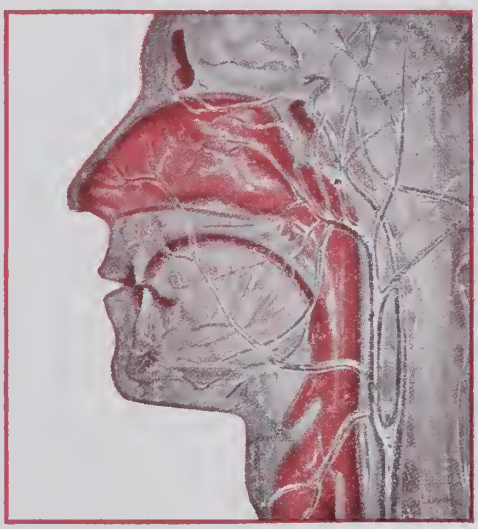
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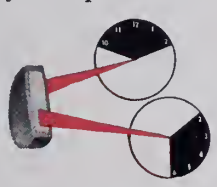
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1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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1. Spoor, H. J.: N. Y. State J. Med. Oct. 15, 1958

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1. Smith, I. M., and Soderstrom, W. H.: J. A. M. A., *170*:184 (May 9), 1959.

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THE JOURNAL
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Editorials • • •

The Vanishing Elixir

A local hospital recently issued a new edition of its *Formulary*—and for the first time omitted all reference to elixirs. Piqued by this strange omission, we turned to Harry Beckman's fine book, *Drugs* (Saunders 1958) to find what that distinguished pharmacologist had to say about elixirs. The answer? Nothing. The word *elixir* does not even appear in the index to this 750 page cyclopedia of modern drugs. And in the current edition of his large (1600 page) "Pharmacology," (Saunders 1957), Torald Sollman mentions elixir only twice—aromatic elixir and elixir terpin hydrate.

What has happened to the elixirs of yesteryear? Can a family doctor practice without elixir of iron, quinine and strychnine? Apparently yes. This seems to be going the way of compound elixir of celery, elixir of buchu, and elixir of anise. The British Formulary still accepts elixir of cascara sagrada and elixir of black haw (*viburnum prunifolium* to us) which is announced as a "uterine sedative" (a wonderful thought!). Have modern tranquilizers completely displaced the old elixir of triple bromides and the elixir of phenobarbital that was our sheet-anchor in the 1920s? Would we be any stronger for consuming elixir of beef and iron, or the NF elixir of cramp-bark (*viburnum opulus*)?

There is a magic in the term itself. The elixir of life—the elixir of love. Etymologists disagree about the origin of the word. The more pedestrian explanation is that an elixir was originally a dry powder and drew its name from the Greek *xeros* which means "dry." It is thus cognate to such words as sere, serene, and serenade. The evening was the dry and placid time of day (Italian *sera*, French *soir*), hence serene and serenade. One may wonder why a pharmaceutical liquid should come from a Greek word for "dry," but there it is.

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A more romantic explanation traces the word to the Arabic phrase *al iksir* which means "the philosopher's stone" that wondrous substance that transmuted baser metals into gold. So the elixir of life—and later the elixir of love.

What is it now? A "sweetened, alcoholic, aromatic solvent holding more than one base." What a dull definition for a substance that once was the very liquor of life itself! Indeed, Sollman dismisses elixirs with the dry comment that "their alcoholic content is such that it is apt to lead to abuses—a fact which must be kept in mind."

So now we have a new gamut af alembics: oxytocics and hematinics; tranquilizers and energizers; vitamins and hormones; anticoagulants and vasodilators; adrenergics and cholinergics; analeptics and analgesics; diuretics and cycloplegics; and so on and on. But elixirs are going with horses, buggies and apothecary's weights.

Rehabilitation and the Private Practitioner

Elsewhere in this issue (page 170) is a paper called "The Doctor's Third Arm." This describes the imaginative and effective rehabilitation program available to many of your patients. Any project that rehabilitates 1300 out of 2100 patients is something to be proud of. The Commission welcomes your participation and your leadership. This is one Government program that does not squeeze out the private practitioner—but rather one which offers him a partnership in a field where the private doctor cannot do the whole job by himself.

When the editorial office received this manuscript, we conducted a private poll among several dozen busy general practitioners. Most of them were unfamiliar with the potentialities of our State Rehabilitation Commission. Perhaps this is the fault of the Commission for failing to publicize itself. Or perhaps it is our fault for failing to familiarize ourselves with this resource. No matter whose fault, the defect can be corrected promptly. The table of Rehabilitation Offices on page 169 is your key to the use of this "third arm."

Electric Brains . . . Or Our Own?

At the Rockefeller Institute there is an indefatigable scientist named V. K. Zworykin who is applying electronics to medical diagnosis. As described in *Think*,* "Dr. Zworykin foresees a gigantic digital computer system centrally located in the United States to process medical information for the entire nation. Individual physicians use the system by means of small control boxes on their desks, linked to the central installation. When a new patient calls, the doctor gives the patient's name and address, or identification number to the computer system. In a few minutes, the patient's complete medical history, from the causes of his grandparents' deaths up to the results of his latest examination, comes from the control box, perhaps in the form of a facsimile print.

"Next, the doctor examines the patient. If

*_Think_, a publication of International Business Machines; this extract is from page 20 of the February 1960 issue.

the diagnosis is not immediately obvious, he can report his findings to the central computer, using it as a sort of giant reference book to help him. Within seconds or minutes—depending on how many other physicians are simultaneously calling upon the computer—there comes back a list of possible diagnoses plus suggestions of additional tests to make."

Dr. Zworykin is not alone. At New York's Mt. Sinai Hospital, Dr. B. J. Davis is, we are told: "working with a different group of researchers in a fundamental study of symptom patterns in diseases, using an ingenious digital computer technic developed by Dr. T. T. Tanimoto of IBM. We can visualize things in the following way: We have data on 100 patients all with the same disease; for example, leukemia. Take a large sheet of tabular paper, and in the first column, write the names of the patients, one below the other. In the second column, place a plus sign if the patient has an enlarged liver, a zero if his liver is of normal size. In the third column place a plus sign if his white blood cell count is above 20,000 per cubic millimeter, a zero if below 20,000. Continue in this way until for each patient there is a *symptom pattern* in +'s and 0's something like this:

John Smith + 0 0 + + 0 + + + + 0 0 + + + + 0 +

"Now if we glance over the sheet we may notice that John Smith's symptom pattern is very similar to Jack Doe's but different from Mary Jones's. What the computer does is to derive a sort of average symptom pattern for the 100 cases, and measure how similar each patient's symptoms are to this average pattern. Dr. Davis or one of his associates will look over the results, and perhaps decide to concentrate on the 60 patients whose symptom patterns are most typical. Then the computer, following a different program, examines the 50 or more different symptoms and notes which of them occur most consistently in these typical patients. And so the analysis proceeds, with rapid, highly flexible communication back and forth between the physician and the machine."

Now these electric brains, we are told, can be used in training practitioners too, as well as in making diagnoses. Thus, we learn that: a novel use of computers in model-making has been "suggested by Instrument Systems Corporation of College Point, New York. They propose constructing from analog computer elements a simulator to train medical students in administering anesthesia, just as flight trainers simulate an airplane for student pilots. The anesthetist training device would include a sort of dummy human being with imitation heartbeat, respiration and other physiologic signs, all under computer control.

"The student could operate the controls to simulate the effect of supplying oxygen, ether, a spinal anesthetic, and so forth. And the instructor could adjust the computer to simulate an emergency—the patient going into shock, for example—just as an emergency can be simulated in a flight trainer and the student pilot taught how to get out of a tailspin or make a crash landing in a fog."

Prognosis should certainly lend itself to the electric brain. We learn that "another line of research is illustrated by the work of New York heart specialist Dr. Menard Gertler and New York University mathematician Dr. Max A. Woodbury. They have used a digital computer to develop the following formula to predict that a healthy young man will have a heart attack by his early 50's:

$$Y = 898.28 - 546.15X_1 + 218.29X_2 - 94.75X_3 + 63.19X_4 + 6.35X_5 + 38.86X_6 + 57.23X_7 + 48.41X_8$$

"The higher Y is, the greater the chance of a heart attack. X_1 is a measure of height, and the minus sign shows that the taller a man is, the less his chance of heart disease. X_2 measures cholesterol in the blood; the plus sign shows that, other things being equal, the more cholesterol, the more chance of heart disease. The remaining variables measure other chemical substances in the blood and take account of heredity and body build."

In an era when we are being criticized for "coldness"—for the loss of the warm and tender human touch, these suggestions are, perhaps, unfortunate. Or can tender loving care be supplied by a robot too?

Y. Modarress, M.D.

R. J. Ryan, M.D.

Sister Celeste Francis, O.S.F

Trenton

Three-Year Review of Staphylococcus Control*

In this compact and unusual review, the authors study the effectiveness of a variety of drugs in the control of staphylococcic infections.

The purpose of this study is to review 3053 hemolytic staphylococcal cultures with sensitivity-tests done in our laboratory* in the years 1956 to 1958 inclusive. The changing sensitivities are to be noted in this study of our local pathogens. Similar studies [1] have been reported from other parts of our country and abroad and it appears that local pathogens have their own peculiarities.[2] Seasons even appear to affect the virulence of different strains as shown by a study done in Florida.[3]

MATERIALS AND METHODS

Hemolytic staphylococci were cultured from wounds, urine, sputum and blood. All subdivisions of hemolytic staphylococci were included as all have been shown to be pathogenic. Blood agar medium was used. Separate impregnated discs were used. These, however, have been shown to be only 80 per cent accurate in 102 reported cases.[4]

All cultures with sensitivity results were catalogued for the three years. Only sensitive or resistant notations were accepted with no degree noted. From these the hemolytic staphylococci were separated.

*From the Departments of Surgery and Pathology, St. Francis Hospital, Trenton, N. J.

RESULTS

Table 1 shows the order of effectiveness of the various antibiotics by years.

TABLE 1

1956	1957	1958
1. Nitrofurantoin	1. Nitrofurantoin	1. Novobiocin-Tetracycline
2. Chloramphenicol	2. Neomycin	2. Novobiocin
3. Novobiocin	3. Novobiocin	3. Chloramphenicol Nitrofurantoin Erythromycin
4. Erythromycin	4. Chloramphenicol	4. Tetracycline

Tables 2, 3, and 4 give analyses of each year's study. Where the number of cultures was insignificant the drug has been deleted.

TABLE 2—1956

	Sensitive Cultures	Resistant Cultures	Per Cent Effective
1. Nitrofurantoin	126	—	100
2. Chloramphenicol	97	7	93.2
3. Novobiocin	76	8	90.4
4. Erythromycin	53	8	86.9
5. Neomycin	22	10	68.7
6. Tetracycline	72	36	66.6
7. Streptomycin	40	56	41.6
8. Penicillin	27	83	24.5

TABLE 3—1957

	Sensitive Cultures	Resistant Cultures	Per Cent Effective
1. Nitrofurantoin	142	6	96.4
2. Neomycin	114	11	91.1
3. Novobiocin	152	16	90.4
4. Chloramphenicol	21	6	77.7
5. Penicillin	19	8	70.3
6. Streptomycin	22	15	62.8
7. Tetracycline	100	70	58.7

TABLE 4—1958

	Sensitive Cultures	Resistant Cultures	Per Cent Effective
1. Novobiocin-Tetracycline (Panalba®)	96	8	92.
2. Novobiocin	240	23	91.
3. Chloramphenicol	212	52	80.
Erythromycin	198	48	80.
Nitrofurantoin	57	14	80.
4. Tetracycline	170	64	72.
5. Penicillin	121	130	48.
6. Streptomycin	68	89	43.

SUMMARY AND CONCLUSIONS

THE efficacy of nitrofurantoin is obvious and enjoys popular use in urinary tract infections. Novobiocin alone appears consistently effective and only questionable cumulative effect is realized by adding tetracycline. The versatile chloramphenicol was useful each year. Erythromycin continues to warrant consideration for staphylococcus.

717 Hamilton Avenue

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NEW JERSEY REHABILITATION COMMISSION

District and Local Offices

Administrative Office:
P. O. Box 845
38-40 South Clinton Avenue
Trenton 5, New Jersey
EXport 2-2131, Ext. 8262

Atlantic City—Schwehm Building, Atlantic City 5-5965
Bridgeton—22 Washington Street, Glenview 1-9098
Camden—413 Broadway, Woodlawn 6-2893
Hackensack—10 Banta Place, Diamond 2-0804
Jersey City—895 Bergen Avenue, Oldfield 3-2350
Morristown—Washington Building, Jefferson 9-3660
Newark—309 Washington Street, Market 3-4235
New Brunswick—96 Bayard Street, Kilmer 5-8120
Paterson—35 Church Street, Armory 1-3050
Trenton—38 South Clinton Avenue, Export 2-2131, ext. 8117
Union—480 Chestnut Street, Murdock 6-3000

Herbert Bloom, M.D.*
Beatrice Holderman*

Trenton

The Doctor's Third Arm: The Rehabilitation Program

Not enough of us know about this useful program available to all practitioners in New Jersey —a resource which preserves our traditional mode of practice but makes Government facilities available when and where needed.

Are You Missing Out on a Chance to Hep Your "Chronic" Patients?

Believe it or not, you have available right here in New Jersey an instrument to help you rehabilitate your patient with chronic illness. At your request, this assistance is available through a State-Federal program, if your patient meets these simple criteria:

(1) He lives in New Jersey.
(2) He is of employable age—that is, age is not the reason he is unemployed.
(3) He has a disabling illness—physical or mental.
(4) His work background and disability are such that with medical or surgical treatment, prosthetics, vocational guidance or job training, the patient can be restored to gainful employment.

This is *not* a charitable or socialized program. To the extent that they can afford to, patients pay for medical services, prosthetic appliances, carfare, books, supplies, tools and subsistence. If the patient cannot pay, the New Jersey Rehabilitation Commission will defray the costs. Most of these patients were taxpayers before they became disabled. Through their taxes they contributed to this program at a time when they did not need this help. Thus, in being aided by the Commission, they are not objects of charity; they are getting a return on their tax investment made during happier years.

The official definition of rehabilitation is that it is the return of a person disabled by disease or accident to his greatest physical, mental, emotional, social, economic and vocational usefulness. Where a disability exists, the attempt is made to eradicate or minimize the disability. Where the disability cannot be improved, attempts are made to circumvent the disability by appliances and training for employment which is consistent with the disability. The goal of the program is to restore the patient to the status of a self-sustaining citizen.

These are fine words. What do they mean in practice? Let's look at the 1959 record. In that year, 2100 New Jersey men and women were accepted for service; and 1316 were effectively rehabilitated. This does not mean that amputees were given crutches and told to sell pencils. It means that 1316 human beings —not cases, but human beings—are gainfully employed and socially adjusted whereas previously they had been disabled. Rehabilitation services are by no means limited to ortho-

*Chief Medical Director and Director respectively of the N. J. Rehabilitation Commission.

pedic disabilities; indeed, orthopedic problems constitute only a third of our caseload. To offer some picture of the kaleidoscope of rehabilitative services, look at our 1959 record:

	Accepted for Services	Rehabilitated
Orthopedic	667	443
Amputation	384	252
Cardiac	186	119
Tuberculosis	140	116
Mental deficiency or retarded	181	114
Hearing defects	140	88
Psychoneurosis	59	25
Visual defects	74	50
Epilepsy	82	27
Arthritis	37	17
Psychosis	41	23
Hernia	16	8
Diabetes	10	8
Speech handicaps	23	7
Personality disturbances	48	15
Other disabilities	14	4
Total	2102	1316

In each case, the vocational counselor, the physician or medical consultant and the applicant work as a team to develop a vocational objective and a rehabilitation plan for the individual. All services then are directed toward attainment of the objective; and all are integrated into a rehabilitation plan to assist the disabled to become self-sustaining men and women. In a case referred by a general practitioner for example, the referring physician receives a fee from the Rehabilitation Commission for a complete physical and medical examination. The referring physician indicates which consultative services are necessary and these are obtained through the Commission. The Commission will accept the person for service if feasible for rehabilitation. If neurosurgical consultation is necessary, the Commission pays the fee for such consultation in accordance with an established fee schedule reviewed by a committee of professional people. If surgery is necessary, and the patient is unable to pay, the Commission will underwrite hospital expenses and surgical fees in accordance with the established fee schedule. After maximum improvement has been obtained, the Commission will help guide, obtain and even train the patient for suitable employment.

The Rehabilitation Commission helps bridge the gap from restoration of the human being through acute medicine to rebirth as an independent, *not dependent* member of society through vocational rehabilitation.

The fee schedule has been established at a slightly lower scale than Blue Shield and compares favorably with other governmental fee schedules. Because of budgetary requirements, such a fee scale is necessary. At the same time, the Commission is oriented primarily toward the patient and wishes to discourage its use as a type of insurance program. It should be emphasized that the Commission does not single out individual physicians for its referrals, but utilizes the services of the patient's own physician. Most often, consultation or surgical treatment will be obtained from a physician specified by the patient or the referring source.

What does this constructive program cost the taxpayer? In a sense, it costs nothing. Magic? Juggled bookkeeping? No—plain arithmetic. Through his increased taxes, a rehabilitated worker pays back in three years all that has been expended on him. If he has a 15-year working life ahead of him (most have much more) he pays in added income taxes, 5 times the cost of the program. Actually, the average post-rehabilitation working time is closer to 20 years—which means, in plain English, that he will pay back in income taxes $7.00 for every $1.00 invested in his rehabilitation. And all this without loss of self-respect, without socialization, without charity!

In this connection, the following paragraphs from the October 24, 1959 *Journal of the American Medical Association* (171:1107) are appropriate:

> "Private practitioners and county and state medical societies and hospitals have been active in the provision of services and in guidance of the program. About one-third of referrals of disabled persons to state rehabilitation agencies come from physicians, hospitals, and welfare agencies. The physician is usually one of the first to see an injured person, and has close knowledge of circumstances surrounding disabilities that arise out of disease or congenital difficulties. There is opportunity for more referrals from physicians if more of them are aware of the services available. A survey just completed among physicians in one of our more populous areas points up this fact. The physicians who were interviewed were from specialty groups most likely

to see patients who might be eligible for rehabilitation services. As a whole, these physicians had relatively little knowledge about their state rehabilitation agency. One-third of them did not know that the agency existed, another one-third knew nothing about the agency except the bare fact that it did exist. Only five per cent of the practitioners knew the general eligibility requirements!"

Even those who knew that there was such a resource as a State Rehabilitation agency often made no use of it and expressed interest and surprise when the possibilities were explained.

In explaining operation of the agency, the JAMA article goes on:

"An applicant talks with a counselor, either in an office of the rehabilitation agency or in the applicant's home. The applicant is asked to furnish medical data concerning his disability. In its absence, the agency will provide for an examination, and, if the services of a specialist are required, the agency will ask for it.

"If an applicant is accepted, a program of rehabilitation services will be formulated to include these measures as required: (1) medical diagnosis to learn more about the disability and to help to determine the program, the need for additional medical services, and the individual's work capabilities; (2) provision of prosthetic appliances; (3) counseling and guidance, including psychological testing, to help attain a vocational objective; (4) training, including occupational training and adjustment training for the blind; (5) maintenance and transportation during treatment, training or any other phase of the rehabilitation process; (6) tools, equipment, licenses or initial stocks and supplies, if these are necessary to give the rehabilitated individual a fair start; (7) placement in a job comparable with the individual's physical and mental capabilities and (8) follow-up to ensure that the rehabilitated person is successful and that both he and his employer are satisfied."

The private practitioner is the backbone of care. Sometimes though, the private practitioner's resources are not quite enough. Need for more help may arise because of the chronicity of the illness, lack of motivation, excessive amount of medical time required, extensive residual impairment or need for highly specialized correctional technics. Under these circumstances, the practitioner's efforts may be supplemented by help from other disciplines in the non-medical and paramedical fields, provided they are integrated in a teamwork pattern. Other disciplines which apply their professional technics to achieve complete adjustment of persons with a long-term illness are those concerned with occupational therapy, special education, administration, sociology, social work, psychology, nursing, religion, vocational counseling, physical therapy, therapy for the blind, brace making, psychiatry, vocational training, and medical and surgical care. Moreover, we must not forget that the patient, too, is a member of the team. The team also includes a medical consultant who is relied upon to help maintain direction for the patient's plan. As Dr. Earl F. Hoerner, Senior Medical Officer of the Disability Determinations Service, N. J. Rehabilitation Commission, puts it: "This is rehabilitation—the use of paramedical services through an integrated pattern—and teamwork—the achievement of complete readjustment of patients and meeting of their total needs."

Mary Switzer, Director of the U. S. Office of Vocational Rehabilitation, says it succinctly this way:

"Nearly 90,000 human beings will be salvaged from life's scrapheap this year through a remarkable government program on which the taxpayers actually turn a profit. For want of a more imaginative name, the program is called 'vocational rehabilitation.' It combines modern medical treatment, special training and job placement services to restore disabled men and women to useful self-supporting employment.

"As a return on this investment, the nation can count 81,000 alumni of vocational rehabilitation programs who resumed productive work during 1959."

To refer a patient—or to get more information—communicate with the nearest office of the New Jersey Rehabilitation Commission. A list of these offices will be found on the bottom of page 169.

38-40 South Clinton Avenue

R. D. Harley, M.D

J. E. Mishler, M.D

Atlantic City

Dexamethasone* in Ophthalmology

Dexamethasone has been used rather successfully for the treatment of a variety of ocular inflammatory disorders, but like other steroids is contraindicated in fungus infections and herpes simplex involving the eye.

The usefulness of adrenocortical steroids in ophthalmic conditions[1] has been well established. Inflammatory diseases involving the anterior segment of the eye respond well in a high proportion of patients. Posterior segment inflammatory states including uveitis show a less favorable response to steroid therapy. In optic neuritis, the therapeutic response to steroids is often favorable. Adrenocortical steroids do not influence the progression of degenerative diseases of the eye.

Dexamethasone, the most active of a series of recently synthesized 16-methyl substituted hydrocortisone analogs is a potent and effective adrenocortical steroid presently available.

Clinical trials were carried out on a variety of inflammatory ocular conditions in order to judge the effectivity of this steroid compound. Since most of the diseases are anterior segment inflammations the following topical preparations were used:

Solution dexamethasone 0.1 per cent, solution dexamethasone 0.1 per cent with neomycin 0.35 per cent and an ointment preparation dexamethasone .25 per cent with neomycin 0.35 per cent. Tablets of dexamethasone 0.5 milligrams were used in certain intraocular inflammations or in anterior segment disease not influenced by topical medication.

The cases were unselected from routine clinic and office practice. Clinical evaluations were made by independent observers.

CATARRHAL CONJUNCTIVITIS

Fifteen patients with acute and subacute catarrhal conjunctivitis were treated with the solution of dexamethasone 0.1 per cent with neomycin 0.35 per cent. The drops were instilled every two hours for three days; and four times a day until after the condition was healed for three to five days. Five of these patients showed excellent improvement in 36 to 48 hours. Five patients showed good improvement in one week. The remaining five showed a fair response to the treatment which continued for three to four weeks.

NON-PURULENT CONJUNCTIVITIS

Five patients with chronic conjunctivitis which had been present for several months were treated with the solution dexamethasone 0.1 per cent with neomycin 0.35 per cent. Three patients showed a good response in two weeks and two showed a fair response within

†Dexamethasone for this clinical trial was supplied by Merck, Sharp and Dohme Research Laboratories, West Point, Penna.

1. See McLean, J. M. *et al.* in the Transactions of the American Academy of Ophthalmology, 55:565 (1951). *Also see* Gordon, D. M.: North Carolina Medical Journal, 19:463 (November 1958); and *also see* Aggatson, H.: American Journal of Ophthalmology, 34:1655 (December 1951).

a month when the medications were used every three hours. All had been treated unsuccessfully for at least a month with other medication prior to starting on the new solution. It was necessary to continue the present treatment for two weeks after all symptoms had subsided. In two cases in which treatment was stopped too early, the symptoms reappeared and prolonged treatment was required.

KERATITIS

Six patients with keratitis were treated with the solution dexamethasone 0.1 per cent and neomycin 0.35 per cent. Five patients with superficial punctuate keratitis responded well and were cleared in one week. One patient developed an infiltrative keratitis secondary to a severely embedded foreign body but the inflammation cleared in five days on the dexamethasone 0.1 per cent and neomycin 0.35 per cent.

ALLERGIC BLEPHARITIS

Five patients with unilateral or bilateral edema of the lids diagnosed as allergic in nature were treated with the ointment preparation of dexamethasone 0.25 per cent and neomycin 0.35 per cent. Two patients with a previous history of allergy were discovered to be sensitive to cosmetics. These patients cleared rapidly in 24 hours. Two patients showed improvement in three days and the symptoms abated after two weeks of therapy. One patient showed improvement but needed further therapy for one month. Systemic antihistaminics were required to supplement treatment for this patient.

CORNEAL ULCERS AND MARGINAL ULCERS

Two patients with central corneal ulceration were treated following removal of foreign bodies and scraping of rust rings. The areas healed quickly with the use of dexamethasone 0.1 per cent and neomycin 0.35 per cent drops every two hours for three days and then four times daily for two weeks. At the end of three weeks the areas showed mild infiltration at the site of the lesion which disappeared completely in two weeks. Three patients with marginal corneal ulcers responded well to treatment and exhibited definite signs of improvement in 36 to 48 hours. Treatment was continued for two weeks in all six patients.

EPISCLERITIS

Three patients with episcleritis were treated with the dexamethasone 0.1 per cent solution. The symptoms of all three patients subsided promptly but in one patient the inflammation recurred after a week. Dexamethasone tablets 0.5 milligram were prescribed four times daily for a week and the inflammation cleared promptly. The solution was used four times daily for another week and the patients remained free of any further symptoms or signs. Another patient had a recurrence one month later. Continuation of topical treatment for an additional three weeks cleared the inflammation.

IRIDOCYCLITIS

Nine patients with acute iridocyclitis were treated with topical dexamethasone 0.1 per cent and atropine sulfate 1 per cent. One patient responded excellently to the medication in three days and was cured in two weeks. Seven patients showed a good response to the medication in about a week. One of these patients was continued on cycloplegic medication because of the plastic adhesions. All seven patients cleared in two weeks. One patient showed fair response to the topical medication and was continued on cycloplegic medication in addition to dexamethasone 0.5 milligram tablet orally, four times daily for two weeks. The last patient required treatment for two months before the eye was completely cured. All nine patients were kept on topical medication for

two weeks after all signs of inflammation had subsided.

POSTOPERATIVE CATARACT EXTRACTIONS

Six patients who developed a low grade iritis following cataract surgery were put on dexamethasone 0.1 per cent solution with neomycin 0.35 per cent three times daily on the 14th postoperative day. Three patients showed excellent results with rapid clearing of the operated eyes. Two patients showed good results with slower clearing of the eyes and a lessening of symptoms. One patient developed a large marginal corneal ulcer after the patch was removed and topical dexamethasone 0.1 per cent with neomycin 0.35 per cent was begun. The corneal ulcer healed following a continuation of the patching for one week.

UVEITIS

Two patients had posterior uveitis. One had an acute exudative chorioretinopathy which was treated with 3 milligrams of dexamethasone daily for two months. The lesion appeared to be unchanged on steroid therapy and gradually subsided into a healed scar over a period of four months. Another patient had a non-granulomatous uveitis with numerous keratitic precipitates and a vitreous so cloudy that a fundal reflex was barely possible on the first visit. Dexamethasone tablets 3 milligram daily by mouth for one month and then 2 milligram daily for two months produced immediate improvement and a final visual acuity of 20/20. Topical dexamethasone 0.1 per cent was used four times daily in addition.

OPTIC NEURITIS

Two patients with severe optic neuritis were treated with topical dexamethasone 0.1 per cent solution and dexamethasone tablets 6 milligram daily for two weeks. There was marked reduction in the nerve head swelling in two weeks and the dosage was reduced to 3 milligrams daily. The return of vision to normal occurred in one month. The oral dexamethasone was discontinued but the topical solution was continued for a month. Visual fields returned to normal, except for an enlarged blind spot.

Diagnosis	Number of Patients	Excellent Response	Good Response	Fair Response	Per Cent Excellent or Good Response
Catarrhal conjunctivitis	15	5	5	5	67
Chronic conjunctivitis	5	0	3	2	60
Keratitis	6	3	3	0	50
Allergic blepharitis	5	2	2	1	80
Central corneal ulcers	2	2	0	0	100
Episcleritis	3	0	3	0	100
Iridocyclitis	9	1	6	2	78
Postoperative cataract extractions	6	3	2	1	84
Uveitis	2	0	1	1	50
Optic neuritis	2	0	1	1	50
	55	16	26	13	75

There were no "poor" responses.

COMMENT

Dexamethasone with and without an antimicrobial was effective in treating ocular inflammations involving the anterior segment. This drug, like other steroids, is contraindicated for topical use in herpes simplex of the cornea and ocular fungus infections.[2] Intraocular inflammations responded well to systemic dexamethasone when indicated. It is important to use topical steroids every 30 minutes to 1 hour in severe inflammatory lesions of the anterior segment. When secondary infection is present concomitant antimicrobial therapy is required. In recalcitrant infections cultural studies are indicated. The minimal initial dose of systemic dexamethasone is 3 to 5

2. Harley, R. D. and Mishler, J. E.: Transactions of the American Academy of Ophthalmology, 63:264 (1959).

milligrams daily or the equivalent in other steroids. The dose can be decreased slowly as soon as a good response is secured.

SUMMARY

1. Under the Merck tradename, Decadron®, the steroid, dexamethasone was used for the treatment of 55 patients suffering from a variety of ocular inflammatory diseases.

2. Dexamethasone, with and without an antimicrobial was effective in treating ocular inflammations involving the anterior segment.

3. Intraocular inflammation responded well to systemic dexamethasone.

4. Topical dexamethasone had a ' stinging" effect in twenty patients and a "burning" effect in two. No serious sequelae were noted.

1616 Pacific Avenue

If Your Patients Travel . . .

New and simplified quarantine procedures now are being followed at airports.

Principal change is elimination of group clearance on arrival of planes from foreign countries. Under the new procedures, if the aircraft captain certifies that no illness has been observed during flight, only individual clearance of passengers is required. Group clearance had been maintained to prevent spread of disease by travelers who might have symptoms of quarantinable illness* on arrival. The only major airport where passengers will still be kept in groups is Miami.

Your patients should know that the new procedures stress the responsibility of travelers for maintaining valid immunization records.

International quarantine emphasizes the prevention of illness through immunization of travelers, control of insects, cleanliness of conveyances, and safeness of food and water.

Vaccination against smallpox is of basic importance for international travelers. Citizens and aliens entering the United States (except persons coming from exempt areas†) *must have international certificates of smallpox vaccination*, received within 3 years of arrival. Persons not properly immunized may be vaccinated at port of entry by a quarantine officer. If they have recently been in an infected area, they may be detained for 14 days.

Individuals planning trips to an area where smallpox is epidemic should be successfully vaccinated, or revaccinated, within six months of arrival in the infected area.

Travelers who have been in a yellow fever infected area within six days of arrival at United States ports are required to present an international certificate of yellow fever vaccination received within six years of arrival. This requirement also applies if the traveler is bound for certain areas in the southern part of the United States and possessions. The nation has not had a yellow fever outbreak since 1905; but in several southern States and United State possessions the mosquito that transmits this disease is still present.

Travelers who have been in a cholera infected area within five days of arrival at United States ports must present an international certificate of cholera vaccination.

Individuals receive international certificates of vaccination form with the passport application. The form may also be obtained from the New Jersey State Health Department in Trenton. Information on vaccination requirements is detailed in Public Health Service Publication 384. You can buy a copy from the U. S. Government Printing Office, Washington 25, D. C., at 30 cents.

*Smallpox, yellow fever, cholera, plague, louse-borne typhus, and louse-borne relapsing fever. Not one of these diseases has been introduced into the Unitd States from foreign countries since a smallpox outbreak in New York in 1947, although quarantinable disease continues to occur widely in other parts of the world.

†Exempt areas are Canada, St. Pierre, Miquelon, Iceland, Greenland, the West Coast of Lower California, Cuba, the Bahama Islands, the Canal Zone, the Bermuda Islands, the British Virgin Islands, Aruba and Curacao.

Announcements • • •

Amputee Conference

A free Congenital Child Amputee Conference and Clinic will be held on Saturday, April 23, 9 a.m. at the Kessler Institute for Rehabilitation, Pleasant Valley Way, West Orange, N. J. This will include demonstrations, slides and documentary films illustrative of rehabilitation procedures employed in specific cases. Dr. Kessler will discuss the genetic psychologic, social and prosthetic problems underlying the rehabilitation of the congenital amputee. Clinical examinations will follow.

This free diagnostic service is available to congenital amputee children through medical referral. The conference is open to all interested persons without charge. Advance registration is requested by writing to the Conference Secretary, Kessler Institute for Rehabilitation, Pleasant Valley Way, West Orange, N. J.

Hematology Course in New York

A full-time 5-day hematology course is announced by N. Y. University for the period May 9 through 14. Patients will be presented, didactic lectures will be given, slides and tissues will be studied and technics will be demonstrated. The course is under the direction of Dr. Leo Weiner. For more details write to Associate Dean, Graduate School of Medicine, 550 First Avenue, New York 16, N. Y.

Calling All Yale Graduates

The Yale School of Medicine celebrates a century-and-a-half of service on October 28-29. The occasion will be marked by a fiesta of exhibitions, orations, clinics, institutes and celebrations. For details, write to Dr. Herbert Thoms, office of the Dean, Yale School of Medicine, 333 Cedar St., New Haven, Connecticut.

A Shipboard Postgraduate Course

Here is an opportunity to combine graduate study with an ocean cruise. The Duke University School of Medicine is sponsoring a Baltic cruise which leaves New York June 8 and gets back to New York on July 5. The cruise will visit Russia, France, Sweden, Finland, Germany and Denmark. For details and reservations write to the Allen Travel Service, 565 Fifth Avenue, New York 17. Medical lectures at the clinical and graduate levels will be given on board.

Chest Disease Symposium in June

For the 45th consecutive year the Trudeau School will hold its seminar at Saranac Lake, N. Y., in diseases of the chest. The program runs from June 6 to June 24. Half the time is devoted to tuberculosis and the rest of the time to other diseases of the chest. Enrollment is limited. Tuition fee is $100 for the 3-week session.

For details write to the Trudeau School for Tuberculosis, Box 500, Saranac Lake, N. Y.

Pediatric Hematology

A four-day intensive course in applied hematology in pediatrics is offered for the period beginning June 6. Registration is also accepted for the part of the course dealing with blood grouping, transfusions and jaundice. Tuition is $125 for the full course or $50 for the 2-day "transfusion" course. Also available at $15 is a unique collection of abnormal blood and bone-marrow slides, which may be purchased and retained at that price by any interested physicians. For more details, write to Dr. Irving J. Wolman, 1740 Bainbridge Street, Children's Hospital, Philadelphia 45, Penna.

Obituaries

DR. JACOB J. BELFER

Dr. Jacob J. Belfer, surgeon to both the Police and Fire Department of Trenton, died on February 29. Born in 1906, Dr. Belfer was graduated in 1932 from the medical school of Temple University. After interning at Mercer Hospital, he established an office for private practice in Trenton. He was particularly interested in gynecology and obstetrics, and was a Fellow of the American College of Obstetrics and Gynecology. During World War II, he was with the medical corps on foreign service. In addition to his police and fire work, Dr. Belfer was affiliated with the Trenton General Hospital.

DR. SAMUEL COSGROVE

One of the country's leading obstetricians and hospital administrators died on February 28, with the death on that day of Dr. Samuel Cosgrove. Dr. Cosgrove was the Superintendent of the Margaret Hague Maternity Hospital since its establishment in 1921 until his retirement in 1954. Under his guidance this became one of the major obstetrical centers in the United States.

Dr. Cosgrove was born in Jersey City in 1883. He received his medical degree at Cornell in 1907 and took his internship in Christ Hospital, Jersey City. He then opened an office for general practice in his native city but became increasingly interested in obstetrics and in 1913 gave up general practice to devote his full time to this specialty. He became affiliated with the old Jersey City Hospital as an obstetrician and rose through all ranks in that hospital, eventually becoming Chief of Obstetrics.

He took time out during World War I to become a Major in the Medical Corps and on returning from Service resumed his practice in obstetrics.

He was at one time President of the Rotary Club and of the Salvation Army. He was Trustee of his church and a member of the Board of the Y.M.C.A. He also served as National President of the Cornell University Medical Alumni. He had a tour of duty as President of the State Board of Health.

Dr. Cosgrove was a Diplomate of the American Board of Obstetrics and served as President of the National Obstetrical Society. He was also one of the Trustees of the Medical-Surgical Plan of New Jersey.

DR. HENRY AMEROY HARTWELL

One of New Jersey's most colorful—and—valuable—citizens died on March 6 with the passing that day of Dr. Henry Ameroy Hartwell. Born in 1874, he received his M.D. at Loyola in 1908. He was always a general practitioner. A thousand deliveries were matched by 10,000 tonsillectomies. Dr. Hartwell was a distinguished writer, poet and musician. He could play almost any instrument in a modern orchestra—and he composed two dozen musical works. He was a poet and a song-writer. He wrote both the words and music of the well-known carol, "Faith Shall Never Die." He wrote many medical articles; and from his typewriter also came a number of political satires. It became a badge of distinction to be on his mailing list for his annual Christmas-card poem. For more than half a century, he served the people of Hudson County as a general medical practitioner. Two years ago, he was laureate of a Golden Merit Award from The Medical Society of New Jersey.

DR. BENJAMIN M. JOSEPH

At the age of 58 Dr. Benjamin M. Joseph died on February 15. A well-known Jersey City pediatrician, Dr. Joseph was a native of Hoboken. In 1926 he was graduated from the New York University College of Medicine and shortly thereafter entered general practice. Always interested in working with children, he did graduate studies in pediatrics and soon limited his practice to that field. He served the Christ Hospital and the Margaret Hague Hospital in all grades, eventually becoming attending pediatrician. He was also consultant at the B. S. Pollak Hospital.

Dr. Joseph was active in civic affairs. He was director of a bank and served on the board of the Hebrew Home and Hospital of New Jersey. He was well known as an amateur golfer, fisherman and photographer.

DR. RICHARD E. KNAPP

New Jersey lost one of its pioneer radiologists on March 9 with the death that day of Dr. Richard E. Knapp. Born in Hackensack in 1884, he was graduated in 1907 from the College of Physicians and Surgeons (Columbia University). Dr. Knapp was a major in the medical corps in World War I. He early became interested in the then young society of radiology (that was in 1908) and roentgenology and established the x-ray department at the Hackensack Hospital. Dr. Knapp was also interested in banking affairs and was a director of the City National Bank in Hackensack and of the Oritani Savings and Loan Association there. He was also active in the affairs of the Radiologic Society of North America.

DR. JOHN J. MALINOWSKI

Death came on March 2 to John J. Malinowski, a Jersey City general practitioner and industrial surgeon. Dr. Malinowski was born in Jersey City in 1901. In 1926 he received his M.D. at Temple University. He was on the surgical staff of the St. Francis Hospital in Jersey City. Dr. Malinowski was also active in Catholic church affairs. He divided his practice between offices in Jersey City, N. J. and Nanticoke, Penna., but retained his membership in our Hudson County Medical Society.

DR. MAX SPEVACK

At the untimely age of 52, Dr. Max Spevack of Gloucester died on February 8, at the Lourdes Hospital in Camden. A 1931 graduate of the Temple University Medical School, Dr. Spevack was active in the affairs of the Camden County Medical Society. Dr. Spevack was proud to be considered a general practitioner and for a quarter of a century he served the people of Camden County.

DR. MAX H. WEINMANN

One of Essex County's true medical veterans died on February 15 with the passing that day of Dr. Max Weinmann. Born in Newark in 1887, he earned his M.D. at Bellevue in 1910. He returned to his native city after a New York internship and set up an office for general practice—a field in which he remained consistently interested for a half century. For forty years he was associated with St. Mary's Hospital in Orange. He was a senior examiner for the Metropolitan Life Insurance Company and, for many decades was a public school physician. Dr. Weinmann was active in many civic affairs in the Oranges where he had lived since 1914.

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Steric Course of Microbiologic Reactions. Ciba Foundation Study Group No. 2. Edited by G. E. W. Wolstenholme, M.B. and Cecilia M. O'Connor, B.Sc. Boston, 1959. Little, Brown & Co. Pp. 115, with 37 illustrations. ($2.50)

This is a report of a study group which met to discuss the stereochemical specificity of microbiologic reactions. The volume includes reports on hydrogen transfer with pyridine nucleotides; the steric mechanisms involved in the reactions of lactic acid; steroid dehydrogenases and the enzymic reductions of ketones.

The specificity of microbiologic reactions is an integral part and perhaps essential to the complete understanding of enzymic activity and of the fundamental process of biochemistry.

A 4½ page index enables the novice to locate specific references within the text. The book is of primary interest to workers in the field of enzymology, organic chemistry and physical chemistry. Much of the material is for the advanced student and is highly theoretical. Its chief appeal should be to workers in physical chemistry who deal with molecular configurations and enzymatic reaction concepts. I doubt if it will be read by the average clinician, surgeon, practitioner of medicine, or college student, unless he should be working for an advanced degree in this highly specialized field of physical and organic chemistry.

THOMAS K. RATHMELL, M.D.

A Cookbook for Diabetics. By Deaconess Maude Behrman. New York, 1959. The American Diabetes Association, Inc., 1 E. 45th St., New York 17. Pp. 172. ($1.00)

Diet in diabetes in this insulin era has changed considerably from that of even thirty years ago. Before 1920, diet was the cornerstone of treatment in diabetes; as a matter of fact, there was little else that a physician was able to offer his patient. In most instances it was a monotonous starvation diet, with very little variety, but one to which the patient had to adhere religiously.

Insulin changed all this; and soon the pendulum

swung to the opposite extreme. The patient learned that if he wanted to indulge his appetite, the only thing he had to do was to add a few units of insulin. But we know today that a diabetic, though protected by insulin, should carefully follow his diet to avoid complications lurking in the background.

It is therefore refreshing to come across a cookbook for diabetics, which (while adhering to all dietary restrictions imposed on diabetics) cites one appetizing recipe after another which helps one to prepare tasty and tempting dishes—all within caloric bounds prescribed by the physician.

Deaconess Maude Behrman in *A Cookbook for Diabetics* draws on her wide experience of over twenty-five years as a teacher and Director of Dietary Departments at Lankenau Hospital in Philadelphia, and Mercer Memorial Hospital in Atlantic City. Her recipes offer a rich variety of appetizing dishes, proving again that a diabetic does not have to feel like an outcast, and can enjoy culinary delicacies without a feeling of guilt. Any obese patient who wants to reduce may find in this text, many valuable hints on how to diet and enjoy eating.

This booklet is a fountain of information, from which physicians too could profit and gain a better understanding in recommending dietary restrictions for their patients.

OTTO BRANDMAN, M.D.

The Family Medical Encyclopedia. J. J. Schifferes, Ph.D. Boston 1959. Little Brown and Company. Pp. 617. ($4.95)

It is somewhat startling to see a medical book written by a Ph.D. but here it is. The material is arranged alphabetically from abasia to zymurgy. The author has tried to combine simplicity with accuracy, and does rather well. (I wonder, though, if it is not misleading to say, as he does, that "most mentally ill people are not insane.") The book serves as an interesting browsing past-time for lay readers and as a source of first-aid information. Doctors may find it useful in preparing talks to lay groups, since it does give ways of expressing rather complex medical concepts in readily understood lay terminology.

VICTOR HUBERMAN, M.D.

Upper Digestive Tract. By Frank H. Netter, M.D. Part I of Vol. 3, Digestive System (The Ciba Collection of Medical Illustrations). Summit, N. J., 1959. Ciba. Pp. 206, with 172 full-color illustrations. ($12.50)

The first three sections of this volume are devoted to anatomy of the mouth, pharynx, esophagus, stomach, and duodenum. Section IV outlines the functional and diagnostic aspects of the upper digestive tract.

The last three sections deal with inflammatory and neoplastic diseases of the mouth, pharynx, esophagus, stomach, and duodenum.

Dr. Netter's artistic genius predominates throughout the book. The reader gets a stereoscopic view, as if he were actually looking over the shoulders of the surgeon, endoscopist, prosector, laboratorian or microscopist.

The stomatologist, oral surgeon, internist, endoscopist, gastroenterologist, and general practitioner will find an abundance of clinical material at a glance. The illustrations are of particular help to the gastro-intestinal surgeon who could visualize at once the anatomic relationship of viscera, their arterial and nerve supply, as well as the venous and lymphatic drainage. Every modern thoracic and abdominal surgical procedure is included. The text correlates well with the plates and the authors have covered all the recent advances in diagnosis and treatment.

The book is a valuable contribution and will be useful for constant reference.

I. GELBER, M.D.

The Physician and the Law. Rowland H. Long. New York, 1959. Appleton-Century. Pp. 302. ($5.95)

Physicians are more litigation-conscious now than ever before in the history of our art. Mr. Long's little book is practical; and if somewhat dogmatic in spots, has the advantage of definiteness. The legal theories are salted by numerous and illustrative case reports. The book covers the usual chapters in a text like this: malpractice, commitment, autopsies, licensure laws, and medical testimony. It also gives a good deal of material not commonly found in such books. The chapter on artificial insemination, for instance, is an unusual one, and there is a brief section on insurance which includes suggestions on personal health and fire insurance as well as on professional liability. Other topics covered in the book include privileged communications, adoption procedures, blood transfusions, paternity determination, and diagnostic aids as evidence in defense of physicians. The references are to be found at the end of each chapter, an infuriating arrangement. You have to leaf through many pages to find where the chapter ends in order to locate a citation. References at the very end of the book would be so much easier. The author has failed to date his case citations, which is too bad. A lawyer may know whether 80 NW 278 is a modern case or an ancient one, but this book is intended for doctors. However, these are trivial faults in a modest, inexpensive volume that will be useful to any medical practitioner

HENRY A. DAVIDSON, M.D.

County Society Reports

Atlantic

The *Medical Society of Atlantic County* had their regular monthly meeting on February 11 at the Log Cabin, Jerome Avenue, Margate City.

The meeting was called to order by Dr. Louis Rosenberg, President. Dr. Rosenberg welcomed the legal profession as our guests. He then introduced Dr. David B. Allman as moderator for the panel, which consisted of Mr. Herbert Horn, David Perskie, and Anthony Repetto, representing the attorneys and Drs. Harvey Vandegrift, Anthony Merendino, and James Gleason, representing the medical profession. Dr. Allman also introduced Mr. William McAuliff, an attorney for the American Medical Association, who gave a short talk about physicians and lawyers, and relayed some background on the development of the Interprofessional Code.

Dr. Harry Subin explained the Medical Society's position in reference to Interprofessional Code. Mr. Alexander Blatt spoke on behalf of the legal profession. There were numerous questions from the floor which were directed at both panels after Dr. Gleason and Mr. Repetto had given a few words.

Judge Leonard tactfully summed up the entire meeting when he made the statement that truthfulness was the watchword, and that as long as both societies followed this, there would be a great deal of harmony between them.

From 7:00 to 8:00 p.m., a social hour was held in which members of both professions had ample opportunity to socialize, and this type of program was carried on with a very excellent buffet following the panel discussion. There were 125 members and guests present at this affair which was enjoyed by all.

LEONARD B. ERBER, M.D.

Reporter

Camden

The general session of the *Camden County Medical Society* was called to order at 9 p.m. on March 1 by the president, Dr. Vincent T. McDermott. The meeting convened in the Society's auditorium with forty-four members present.

Dr. Chauncey K. McGeorge, Program Chairman, introduced the speaker of the evening, Mr. James R. Zotti, Assistant Manager of Physician Relations Section of the Medical-Surgical Plan of New Jersey. Mr. Zotti gave a factual presentation of the three new Blue Shield riders adopted last summer. He reported that 65 per cent had subscribed to rider A which allowed an increased number of days of hospitalization, further out-patient coverage, as well as diagnostic x-rays and laboratory work outside the hospital; rider B limited extended coverage to increased medical care in the hospital; and rider C extended the coverage of out-patient surgery. An interesting question and answer period followed during which Mr. Zotti gave specific answers to the apparent satisfaction of the members.

The following Associate members were administered the oath, signed the register and were introduced: Drs. Armand J. Angulo, Irving N. Beran, Harry M. Carnes, Norman H. Eckbold, Jutta A. Gave, John J. Lebeau, Warren M. Nicholas, Morton W. Perkoff, Vito A. Valecce and William A. West.

Applications for membership were received from Drs. Otto T. Boysen, Heldi Rink and Vojslav Mitrovic and referred to the Board of Censors and Membership Committee.

A letter from Dr. Helen F. Schrack was read in which she thanked the Society for the resolution sent her commending her on receipt of the Elizabeth Blackwell Award. A standing ovation was given to Dr. Schrack who replied with a word of thanks.

The names of Drs. Jacqueline Coant and Marcel J. Schulmann were presented for balloting and it was voted that the Secretary cast the ballot electing them to Associate membership.

FREDERICK W. DURHAM, M.D.

Reporter

Hudson

With Dr. Charles A. Landshof presiding the regular meeting of the *Hudson County Medical Society* was held at Murdoch Hall, Jersey City Medical Center on Tuesday evening, March 1.

Guest speaker of the evening was Roy A. Morrow, M.D., Assistant Attending Surgeon, Jersey City Medical Center and Margaret Hague Maternity Hospital. Dr. Morrow's topic was entitled "Surgery of the Newborn." Many doctors participated in a discussion from the floor.

The following resolution was passed unanimously by the Society:

> *Whereas* on May 4, 1954 the Hudson County Medical Society passed a resolution recommending to the New Jersey Medical-Surgical Plan
>
> a. that in making payment for surgical procedures, the Plan designated the amount as payable for *surgical services*, and not as the *surgeon's fee*;

b. that the Plan pay both the surgeon and the assistant (or the referring doctor, as the case may be);

c. that if sufficient funds are not available to pay both the surgeon and the assistant (or referring doctor) *in full,* the Plan divide the payment proportionately between the two; in other words, the Plan compensate in part, both the surgeon and the assistant (or referring doctor);

d. that the patient be notified by the Plan of the payment being made to the surgeon and to the assistant (or the referring doctor);

Whereas this is still considered a fair and ethical handling of the situation;

Be It Resolved that the Hudson County Medical Society reaffirm its position and so inform the New Jersey Medical-Surgical Plan that it wishes the practice of apportionment of surgical fees to be continued.

Be It Further Resolved that a copy of this resolution be sent to each component county society for their approval.

Drs. Charles C. Abbott and Larry L. Feder were elected to Active membership in the Society. Drs. Paul J. Coleman and Patrick H. Lehan of Jersey City; Dr. Nicholas A. Marchese of Union City and Dr. Gerta Schwarz of Weehawken were elected to Associate membership.

Dr. Landshof announced that there would be a special meeting of the House of Delegates on March 13, and urged all Delegates to attend this important meeting.

A special tribute and a moment of silence was observed in memory of our past president and colleague, Dr. Samuel A. Cosgrove, who passed away February 28.

Following the business meeting a collation was served.

ROY A. MORROW, M.D.

Reporter

Mercer

Dr. W. Paul Havens, Professor of Medicine, Jefferson Medical College, discussed "Problems of Hepatitis Today" at the March 9th meeting of the *Mercer County Component Medical Society,* under the chairmanship of its President, Dr. John A. Kinczel.

During a brief business session, which followed the scientific program, the following action was taken:

Dr. L. E. MacDermid, of Bordentown, was nominated to receive the A.M.A. General Practitioner of the Year Award. The Society approved a proposed amendment to the Constitution of The Medical Society of New Jersey, relative to county society representation on the Board of Trustees, as recommended by the Union County Medical Society.

A resolution, adopted by the New Jersey Chapter of the American Academy of General Practice, urging the Medical-Surgical Plan of New Jersey to continue the apportionment of available surgical benefits in surgical procedures, was unanimously opposed.

The following resolution, offered by Dr. Albert F. Moriconi, was unanimously adopted:

"Whereas, the members of the Mercer County Component Medical Society have always disapproved of any form of apportionment of fees, no matter in what terms designated, and

"Whereas, the Mercer County Component Medical Society went on record several years ago, by resolution, disapproving the adoption of any plan by the Medical-Surgical Plan of New Jersey which permitted the allocation of a portion of the surgeon's fee to another physician; and

"Whereas, despite the opposition of the Mercer County Component Medical Society and its delegates, this plan was adopted by The Medical Society of New Jersey, and following its approval, the Medical-Surgical Plan of New Jersey incorporated item 31, with an explanatory paragraph in its Service Report; and

"Whereas, the American College of Surgeons has flatly, definitely, and emphatically disapproved of the apportionment of fees and

"Whereas, the American Medical Association has also disapproved of the apportionment of fees, and

"Whereas, the continuation of item 31 and its explanatory paragraph in the Service Report of the Medical-Surgical Plan of New Jersey implies agreement by all participating physicians with its unpleasant connotations;

"Therefore, Be It Resolved, that the Mercer County Component Medical Society go on record as again opposing an apportionment of fees in any form, and further

"Be It Resolved, that item 31, with explanatory remarks be stricken from the Medical-Surgical Plan of New Jersey's Service Report, and be it

"Further Resolved, that this resolution be placed before the House of Delegates for appropriate action at the next annual meeting of The Medical Society of New Jersey."

Physicians elected to Active membership included Dr. Mary Ann B. Bartusis; Dr. Alex J. Krawczun; Dr. John C. Wood; and Dr. Richard L. Barach (Dr. Barach, on transfer from New Haven County (Connecticut) Medical Association.)

R. N. CAGAN, M.D.

Reporter

Middlesex

Roosevelt Hospital was host to the *Middlesex County Medical Society* at its regular monthly meeting on February 17. The meeting was called

to order by the president, Dr. John A. Smith at 9:00 p.m.

New applicants were recommended for election to Associate membership, by the Judicial Medical Ethics Committee: Drs. Marshall Smith, Jr. of New Brunswick and Jacob Seltzer of Perth Amboy. Credentials being in order, these two applications were sent to The Medical Society of New Jersey for approval.

Expressions of sympathy were extended to Mrs. Calvert R. Toy upon the death of her husband and to Drs. F. M. Clarke and Ralph J. Faulkingham, upon the death of their wives.

The resolution of opposition to the Pilot Plan on Funded Medical Eye Care was passed without a dissenting vote, and a copy of this resolution forwarded to each county medical society in New Jersey and to the Board of Trustees of The Medical Society of New Jersey.

A resolution was presented to the Middlesex County Medical Society by Dr. Charles H. Calvin, immediate past president and Chairman of the Board of Trustees of the New Jersey Chapter, American Academy of General Practice, as follows:

RESOLUTION

Whereas, for the past years the Medical-Surgical Plan has apportioned part of the surgeon's fees for his assistant at an operation in which they each fill out separate forms and render separate bills, and

Whereas, A representative of Blue Shield states that due to numerous protests from the College of Surgeons, there is serious consideration being made to eliminate the apportionment of available surgical benefits in the 1960 Medical Surgical Contract;

Whereas, this allowance is a fair procedure, and since it provides some income for the young general practitioner who spends many hours of each day assisting;

Be It Resolved, that the New Jersey Chapter, Academy of General Practice urge the Medical-Surgical Plan to continue the apportionment of available surgical benefits in surgical procedures.

The expense for food for members of the County Medical Society at the joint dinner meeting with the pharmacists will be paid by the Society.

Harry L. Shapiro, Ph.D., Curator of Anthropology at the American Museum of Natural History, gave an interesting and scholarly lecture on "Youthful Offenses in Modern Culture." Dr. Shapiro stated that causes of delinquency are very complex, the main ones being: (1) Urban living which weakens group conformity, (2) cultural barriers between generations due to rapid technologic changes. Immigration, economic factors, drug addiction, broken homes, and psychiatric problems are minor causes and are in themselves due to cultural factors.

THOMAS I. STEINBERG, M.D.

Reporter

Monmouth

Dr. Harold Gabel, Program Chairman, introduced the speaker for the scientific session of the February 21 meeting of the *Monmouth County Medical Society.* This session was sponsored by the Monmouth County Heart Association. Dr. Daniel J. Larson, Assistant Professor of Medicine at Columbia University, spoke on "The Effect of Commissurotomy on the Natural History of Mitral Stenosis." Dr. Larson's interesting statistics and commentary stressed the need for a reappraisal of our indications for mitral valvular surgery.

The business meeting was called to order by the president, Dr. Lester A. Barnett, at 10:15 p.m. Dr. Barnett noted the excellent attendance at the meeting and commended the membership for their interest. Elections resulted in the following:

President—Dr. Morton F. Trippe; President-Elect—Dr. William J. D'Elia; Secretary-Treasurer—Dr. Donald W. Bowne; Assistant Secretary-Treasurer—Dr. George G. Green; Reporter—Dr. Leonard S. Danzig; Executive Committee—Dr. Anthony DeSpirito, Dr. Harold Gabel and Dr. Martin R. Rush; Chairman of the Judicial Committee—Dr. Abraham Rosenthal; Delegates to State Society—Dr. Louis F. Albright, Dr. C. Byron Blaisdell, Dr. John C. Clark, Dr. David McCreight, Dr. Herman O. Wiley, Dr. Frank Niemtzow and Dr. Martin R. Rush; Alternate Delegates to State Society—Dr. William L. Wood, Dr. Frederick C. Steller, Dr. Robert S. McTague, Dr. Joseph L. Gluck, Dr. Joseph A. Russo, Jr., Dr. Anthony L. Rifici and Dr. William J. Koch; Nominating Delegate—Dr. Daniel F. Featherston and Alternate Nominating Delegate—Dr. Louis F. Albright.

Elected to Active membership were: Dr. Saul Levinson, Eatontown (Fort Monmouth) and Dr. Louis Salmon, Middletown (ophthalmology). The following were elected to Associate membership: Dr. Aldo Baldy, Long Branch (pathology), Dr. John A. Casazza, Red Bank (general practice), Dr. Francesco DeRobbio, Middletown (general practice and psychiatry) and Dr. Dominick Pagliaro, Spring Lake (orthopedics). Dr. Daniel J. Featherston, Chairman of the Judicial Council of the State Medical Society, presented a code of medical and legal ethics which is hoped will establish a working relationship between lawyers and doctors. A report was approved on membership. Dr. Barnett reported on the emergency session of the Board of Trustees held in Trenton on February 21. It was reported at this meeting that the Blue Cross proposes to include riders for diagnostic procedures in the hospital without provision for physicians' fees. It was also reported that the Medical-Surgical Plan of New Jersey is considering dropping its proposed contract for reduced rates for patients over 65 because of inadequate physician participation.

A spirited and lengthy discussion of these two proposals followed. A hand vote with many abstaining showed 48 to 5 in favor of reduced rates

for people over 65, so that the Medical-Surgical Plan could be available for these senior citizens. The tenor of the discussions suggested that the membership was generally opposed to the rider for hospital diagnostic procedures.

LEONARD S. DANZIG, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on February 16, at 9:00 p.m. at the Medical Society Building. Dr. Julian Cohen, president, officiated.

Dr. Cohen stated that The Passaic County Medical Society's investigation into the circumstances surrounding a death on February 11, has clearly revealed that there was no negligence on the part of the physicians involved. There is no evidence that physicians were unavailable. There is no evidence that physicians acted other than conscientiously and in accordance with their best medical judgment.

The president then read a letter from Dr. Blasingame, Executive Vice-President of the American Medical Association, regarding the Forand Bill. He urged that personal letters and resolutions opposing this bill be sent to our Congressmen and Senators with copies to Wilbur Mills, the Chairman of the House Ways and Means Committee, and to the President of the United States.

A resolution was read from the New Jersey Chapter, American Academy of General Practice, requesting support in urging the Medical-Surgical Plan to continue the apportionment of available surgical benefits in surgical procedures. There is serious consideration being given to eliminating the apportionment of surgical benefits in the new contract. After discussion a motion was made and approved to the effect that we have heard the resolution with interest and will keep it under advisement.

Dr. Cohen called upon Dr. Berkhout to give details in connection with the poliomyelitis campaign. Dr. Berkhout advised the members that they would be receiving post cards in the mail which should be filled out indicating willingness to participate in the program to give the third injection at the "Dollar Clinics." He said that it was an exhilarating experience to see doctors practically unanimously participate in the campaign last year, and he hopes to get the same enthusiastic response from the membership again.

The meeting was then turned over to Dr. Andrew Sporer, Attending Urologist, Barnert Memorial Hospital. Dr. Sporer introduced Francis A. Beneventi, M.D., Professor of Urology, New York Polyclinic, Associate Professor of Urology, New York Hospital; Marvin Levitt, M.D., Chief, Kidney Division, Department of Medicine, Mt. Sinai Hospital and Robert M. Epstin, M.D., Assistant Professor of Anesthesiology, Columbia University. The subject was a Panel Discussion on "Preparation and Management for Surgery of Patients with Renal Impairment" with Dr. Sporer acting as Moderator.

IRVING CHRISMAN, M.D.

Reporter

Salem

The regular monthly meeting of the *Salem County Medical Society* was held on February 19 at the du Pont Penns Grove Country Club with Dr. George A. Nitshe, Jr. presiding.

Benjamin Berkowitz, M.D., Bridgeton, President of the Cumberland County Medical Society, was a guest.

The chairman for the Diabetes Detection Program in Salem County, Dr. Isadore Lipkin, Penns Grove, reported that 1114 tests were made and six new cases of diabetes discovered. Dr. Lipkin expressed appreciation for the cooperation of the participating physicians in this program.

The guest speaker was Dr. Bryan Hoffman, Research Physiologist at the State University of New York in Brooklyn. Dr. Hoffman was sponsored by the Salem County Heart Association as a part of its professional education program. He illustrated a new technic in studying the action of the heart. This has been used for several years in the State University and consists primarily of studying the activity of a single heart muscle fiber through changes in electrical energy caused by drugs or mechanical stimuli.

A lively question and answer period followed this stimulating discussion.

G. F. REICHWEIN, M.D.

Reporter

The 194th Annual Meeting
OF
The Medical Society of New Jersey

Saturday-Wednesday, May 14-18, 1960

HADDON HALL, ATLANTIC CITY

Daily Schedule

Friday, May 13, 1960

8:00 p.m.—Board of Trustees
Bakewell Room, 1st floor

Saturday, May 14, 1960

10:00 a.m.—Registration Opens
Sun Porch, Lounge floor

2:30 p.m.—House of Delegates
Viking Room, 13th floor

3:30 p.m.—Golden Merit Award Ceremony
Viking Room, 13th floor

4:00 p.m.—Open Discussion on Medical-Surgical Plan
Viking Room, 13th floor

8:30 p.m.—Nominating Committee
Bakewell Room, 1st floor

Sunday, May 15, 1960

11:00 a.m.—Reference Committees:
"A"
Room 1333, 13th floor
"B"
Room 1344, 13th floor
"C"
Mandarin Room, 13th floor
"D"
Room 1335, 13th floor
"E"
Room 1337, 13th floor
"F"
Rowsley Room, 1st floor
"G"
Room 1332, 13th floor
Constitution and Bylaws
Bakewell Room, 1st floor

1:00 p.m.—Exhibits Open
Lounge floor

2:00 p.m.—Motion Picture Theatre
Solarium, Lounge floor

2:30 p.m.—House of Delegates (election)
Viking Room, 13th floor

Monday, May 16, 1960

9:30 a.m.—House of Delegates
Viking Room, 13th floor

9:30 a.m.—Motion Picture Theatre
Solarium, Lounge floor

2:00 p.m.—Motion Picture Theatre
Solarium, Lounge floor

3:00 p.m.—General Session
Viking Room, 13th floor

9:00 p.m.—Music and Dancing
Rutland Room, 1st floor

Tuesday, May 17, 1960

9:00 a.m.—Board of Trustees
Bakewell Room, 1st floor

9:30 a.m.—Sections:
Cardiovascular Diseases
Viking Room, 13th floor
Neuropsychiatry
Card Room, Lobby floor
Obstetrics and Gynecology
Tower Room, 13th floor
Otolaryngology
Room 1344, 13th floor

9:30 a.m.—Motion Picture Theatre
Solarium, Lounge floor

9:45 a.m.—Section on Clinical Pathology
Mandarin Room, 13th floor

10:00 a.m.—Sections:
Dermatology
Rutland Room, 1st floor
Metabolism and Ophthalmology (Joint Meeting)
West Room, 13th floor
Orthopedic Surgery
Roberts Room, Chalfonte

12:30 p.m.—Luncheons:
Section on Cardiovascular Diseases and New Jersey Chapter, American College of Cardiology
Bakewell Room, 1st floor
Section on Dermatology and New Jersey Dermatological Society
Rowsley Room, 1st floor
New Jersey Orthopaedic Society
Blue Room, Chalfonte

2:00 p.m.—Section on Medicine
Rutland Room, 1st floor

2:00 p.m.—Motion Picture Theatre
Solarium, Lounge floor

7:00 p.m.—Dinner-Dance
Carolina Room, Chalfonte

Wednesday, May 18, 1960

9:30 a.m.—Motion Picture Theatre
Solarium, Lounge floor

9:30 a.m.—Section on Anesthesiology
Tower Room, 13th floor

10:00 a.m.—Sections:

Allergy
Mandarin Room, 13th floor

Chest Diseases
West Room, 13th floor

Gastroenterology and Proctology
Blue Room, Chalfonte

General Practice
Roberts Room, Chalfonte

Pediatrics
Rutland Room, 1st floor

Radiology
Card Room, Lobby floor

Rheumatism
Room 1344, 13th floor

Urology
Rowsley Room, 1st floor

12:30 p.m.—Special Luncheons:

Section on Anesthesiology
Zodiac B, Chalfonte

New Jersey Chapter, American College of Chest Physicians
Parlor B, Chalfonte

Section on Radiology
Zodiac A, Chalfonte

Section on Rheumatism
Parlor A, Chalfonte

Section on Surgery and New Jersey Chapter, American College of Surgeons
Wedgwood II, Lounge floor

Section on Urology
Bakewell Room, 1st floor

1:00 p.m.—Exhibits Close
Lounge floor

2:00 p.m.—Section on Surgery
Rutland Room, 1st floor

2:30 p.m.—Registration Closes
Sun Porch, Lounge floor

Golden Merit Award Ceremony

Saturday Afternoon, May 14, 1960

Viking Room, 13th floor

3:30 p.m.

The Golden Merit Award, established in 1957, is conferred upon every member of The Medical Society of New Jersey who has held the degree of Doctor of Medicine for fifty years.

Presiding

F. Clyde Bowers, M.D., President

Master of Ceremonies

John F. Kustrup, M.D., Chairman, Subcommittee on Public Relations

Marshals

Presidents of component societies whose members are receiving awards.

General Session

Monday Afternoon, May 16, 1960

Viking Room, 13th floor

3:00 p.m.

Presiding

F. Clyde Bowers, M.D., President

Inaugural Address

Jesse McCall, M.D., President-Elect

Forum

Timely topic of interest to medicine and of national concern. An open meeting for all members of the Society and the Woman's Auxiliary.

Dinner-Dance

Tuesday Evening, May 17, 1960

Carolina Room, Chalfonte

7:00 p.m.

honoring

PRESIDENT AND MRS. F. CLYDE BOWERS

Toastmaster

Albert Abraham, M.D.

Welcome

Mrs. George O. Rowohlt, President, Woman's Auxiliary

Introductions

Mrs. Ralph K. Bush, President-Elect, Woman's Auxiliary

Jesse McCall, M.D., President-Elect

Presentation of Fellow's Key

To: F. Clyde Bowers, M.D., President

By: Kenneth E. Gardner, M.D., Immediate Past-President

Entertainment

All Star Show

Music and Dancing

Motion Picture Theatre

Sunday Afternoon, May 15, 1960; Monday and Tuesday Mornings and Afternoons, May 16 and 17, 1960; and Wednesday Morning, May 18, 1960

Solarium, Lounge floor

9:30 a.m. and 2:00 p.m.

Resuscitation of the Newborn

Special Committee on Infant Mortality of the Medical Society of the County of New York

Based on a report by the Special Committee on Infant Mortality of the New York County Medical Society, this film illustrates the principles and technics for the resuscitation of infants who do not breathe—or whose respiration is irregular—at birth. The physiology of pre- and post-natal oxygenation, and the factors that may contribute to producing respiratory depression in the newborn are described. Through live action delivery room photography, and through animation, the procedures and apparatus necessary for effective resuscitation are shown. The Apgar scoring system (by which the circulatory, respiratory, and neurologic status of the newborn infant can be evaluated) is demonstrated.

10:00 a.m. and 2:30 p.m.

No Margin for Error

The Wm. S. Merrell Company, American Bar Association and American Medical Association

Presents one of the most pressing current problems in legal medicine, the cause and effect of human mistakes in the complex system of the modern hospital. Case histories deal with major causes of in-hospital professional liability action. Mix-up in patient identification, mistakes in blood bank procedure, and error in medication dosage are examples of problems the film reveals.

10:35 a.m. and 3:05 p.m.

Routine Pelvic Examination and Cytologic Method

National Cancer Institute, and the American Cancer Society

This stresses the importance of obtaining vaginal and cervical smears as a routine practice in the physical examination of all women. Such smears, properly obtained, fixed and sent to adequately staffed pathology laboratories for cytologic interpretation, make possible the early diagnosis of uterine cancer. A second objective is to illustrate the requirements of an adequate pelvic examination of women, which also should be carried out routinely, irrespective of complaints referrable to the reproductive tract organs.

11:00 a.m. and 3:30 p.m.

Hospital Sepsis—A Communicable Disease

Amercian Medical Association, American College of Surgeons, and American Hospital Association.

Designed to educate all levels of hospital personnel concerning the many avenues by which infection can be spread throughout a hospital, this film utilizes the staphylococcus by way of illustration and as an example of one of the most important phases of the problem.

11:30 a.m. and 4:00 p.m.

Treatment of Wild Animals with Librium® (Methaminodiazepoxide)

San Diego Zoo

This film pictures the behavior of several species of wild animals before and after treatment with Librium®—a new synthetic therapeutic agent for the treatment of common emotional disturbances. Librium® shows an unprecedented "taming" action in wild, vicious monkeys, tigers, dingo dogs, and other animals. In all species, it was found that all fear and aggression were eliminated by the drug at doses far below those required to produce hypnosis.

Film program arranged and presented through the cooperation of Smith Kline & French Laboratories, Philadelphia, Pa.

Scientific Section Meetings

Tuesday Morning, May 17, 1960

CARDIOVASCULAR DISEASES

Mortimer L. Schwartz, M.D., Chairman, Maplewood
Maurice N. Re, M.D., Secretary, Palisade

Viking Room, 13th floor

9:30 a.m.

Recent Developments in Electrocardiography

Norman Reitman, M.D., Director of Medicine, Middlesex General Hospital, New Brunswick

Discussor: Sidney R. Arbeit, M.D., Jersey City

This paper offers a critical evaluation of some of the newer concepts of bundle branch block, stressing the benign nature of many of these abnormalities. Also reviewed are the more recently reported effects of digitalis upon the electrocardiogram such as paroxysmal auricular tachycardia with block; electrolyte disturbances; and a critical evaluation of the Masters' exercise tolerance test for coronary insufficiency, stressing some of the recent work of Lupeschkin and his associates in attempting to find a more pragmatic criteria for evaluation of coronary insufficiency.

10:00 a.m.

Symposium on Heart Sounds and Murmurs

Moderator: Mortimer L. Schwartz, M.D., Chairman, Section on Cardiovascular Diseases, Maplewood

Participants: Faculty Members, Seton Hall College of Medicine, Jersey City

Robert C. Little, M.D., Professor of Cardiovascular Physiology

Gilbert E. Levinson, M.D., Assistant Professor of Medicine (Cardiology)

Patrick Lehan, M.D., Instructor in Medicine

Paul J. Coleman, M.D., Assistant in Medicine

Theodore H. Goldberg, M.D., Instructor in Clinical Medicine

Discussion: Participants and Moderator
(Individual stethophones will be available for each member of the audience. Sounds will be visualized through oscilloscopes.—Courtesy of Sanborn Company)

An introduction to the physiology of heart sounds and murmurs will be followed by an insight into the normal and abnormal phonocardiogram. Newer aspects of auscultation of the heart will be presented. Splitting about the first sound, splitting about the second sound, systolic murmurs and diastolic murmurs will be leading subjects. Recent data from intracardiac recording of sound will be included. Patient material, when available, individual stethophones and oscilloscopic screens will demonstrate the findings in some acquired and congenital heart lesions.

11:35 a.m.

Present Indications for Heart Surgery

Harper K. Hellems, M.D., Professor of Medicine and Director, Division of Cardiovascular Diseases, Department of Medicine, Seton Hall College of Medicine, Jersey City

Discussor: Alfred R. Henderson, M.D., Asbury Park

Surgical therapy is now available for most congenital and acquired cardiac lesions. The results to be expected from a surgical approach to the cardiac problem vary with the type of lesion as does the surgical risk to the patient. In the selection of patients for cardiac surgery the cardinal principle is to offer this form of management to patients who are showing definite symptoms of disability or who have objective evidence of laboratory tests of major hemodynamic abnormality. Final selection of the patient for surgery involves, therefore, the clinical evaluation of the patient including the routine laboratory studies such as heart x-ray, electrocardiogram, and frequently more elaborate testing utilizing the technics of cardiac catheterization and angiocardiography.

11:55 a.m.

Business Meeting

12:30 p.m.

Luncheon—Section on Cardiovascular Diseases and New Jersey Chapter, American College of Cardiology

Bakewell Room, 1st floor

Reservations: Arthur Bernstein, M.D.
668 Clinton Avenue, Newark

CLINICAL PATHOLOGY

JACOB CHURG, M.D., Chairman, Teaneck
MILTON H. KANNERSTEIN, M.D., Secretary, Newark

Mandarin Room, 13th floor

9:45 a.m.

Symposium on Current Problems in Virus Diseases

Moderator

Elmer L. Shaffer, A.M., Ph.D., Director, Division of Laboratories, New Jersey State Department of Health, Trenton

Recent Advances in Virology

Morris Schaeffer, M.D., Director, Bureau of Laboratories, Department of Health, New York, N. Y.

New technics have made possible revolutionary advances in virology within the past decade. The isolation of a virus, hitherto a noteworthy feat, has now become as commonplace a procedure as is the isolation of bacteria. Within the past few years, over 100 new viruses have been "discovered." Some are clearly responsible for previously undefined disease entities while others are still "in search of a disease." The addition of many more viruses will complicate the problems of diagnosis and interpretation of the role of viruses in health and disease. Eventually, however, there will be but few nameless fevers, exanthemas, respiratory, gastrointestinal, and central nervous system syndromes.

Eastern Encephalitis and Other Neurotropic Virus Diseases

Martin Goldfield, M.D., Assistant Director, Division of Laboratories, New Jersey State Department of Health, Trenton

Since we are unable to make a specific diagnosis by clinical features alone in most cases of central nervous system illness of presumed viral etiology, laboratory studies are essential if the causative agent is to be identified. Viruses causing neurologic disease will be described, the frequency of infections with them reviewed and specimens needed for laboratory identification enumerated. The occurrence of viral central nervous system disease in New Jersey during 1959 will be reviewed.

Clinical Aspects of Virus Diseases

Lewis L. Coriell, M.D., Medical Director, Camden Municipal Hospital, Camden

Clinical management of virus diseases will be discussed including diagnosis and treatment using the facilities available in general practice. Symptoms requiring additional tests will be mentioned. The active and passive prophylactic measures now available will be reviewed.

General Discussion

11:45 a.m.

Business Meeting

DERMATOLOGY

EVA T. BRODKIN, M.D., Chairman, Newark
BENJAMIN B. BURRILL, JR., M.D., Secretary, Montclair

Rutland Room, 1st floor

10:00 a.m.

Syphilis—1960

Edmond Edelson, M.D., Director, Department of Dermatology and Syphilology, Division of Health, Newark

Discussor: Roscoe P. Kandle, M.D., Trenton

The marked, rapid rise in the rate of infectious syphilis and its epidemiology will be discussed. Slides will be presented showing the relative incidence of infectious syphilis in Newark for 1957, 1958, and 1959. Also shown will be colored slides of the various stages of syphilis seen during this period. Modern, simplified therapy for syphilis, and the utilization of the more recently developed diagnostic tests, will be discussed. Dr. Kandle will discuss the paper from his point of view as State Commissioner of Health. He will give an over-all picture of syphilis in New Jersey as compared to other metropolitan areas and states.

10:30 a.m.

Recent Advances in Dermatology

Benjamin B. Burrill, Jr., M.D., Attending Dermatologist, Mountainside Hospital, Montclair

Discussor: E. William Jewell, M.D., Ridgewood

This paper will review for the family physician the dermatologic uses of some of the recent pharmaceuticals. The problem of serious reactions to local anesthetics and the injection of foreign protein will be discussed, together with the make-up of an emergency kit for treating them. Several useful instruments will be described.

11:00 a.m.

Importance of Correct Diagnosis in Treating Skin Diseases

Otto B. Hitschmann, M.D., Associate Dermatologist, Martland Medical Center, Newark

Discussor: John A. Hunt, M.D., Maplewood

Correct diagnosis of even minor skin ailments is not a dermatologic caprice, but is essential and often decisive for success or failure of treatment. Clinical features and corroborative laboratory tests important for the differential diagnosis of some dermatoses will be discussed. Only if suspected and recognized, can the causing agent be eliminated. In this way relapses, overtreatment and/or dermatitis medicamentosa are prevented and cured. Only correct diagnosis will lead to proper and thus successful therapy. Only then will the use of specific and/or systemically acting medicaments become really specific. The risk involved in the use of some drugs is a properly calculated one.

11:30 a.m.

Present Day Management of the Bullous Diseases

Maurice J. Costello, M.D., Professor of Clinical Dermatology and Syphilology, New York University College of Medicine, New York, N. Y.

Great interest has been stimulated in the causes, course, and treatment of the bullous diseases since their favorable response to the corticosteroids. The course of the various forms of pemphigus has been favorably affected and the prognosis is likewise more favorable. Dermatitis herpetiformis, in most instances, has been brought under control but not cured. Though we are on the threshold of conquering this disease, it stil resists complete cure. The control of the various types of erythema multiforme and the better prognosis in the treatment of Stevens-Johnson's disease is discussed.

12:00 noon

Business Meeting

12:30 p.m.

Luncheon—Section on Dermatology and New Jersey Dermatological Society

Rowsley Room, 1st floor

Reservations: Eva T. Brodkin, M.D.
365 Osborne Terrace, Newark

METABOLISM AND OPHTHALMOLOGY JOINT MEETING

Metabolism

George A. Hess, M.D., Chairman, Trenton
Robert H. Areson, M.D., Secretary, Upper Montclair

Ophthalmology

Jay E. Mishler, M.D., Chairman, Atlantic City
Louis A. Amdur, M.D., Secretary, Jersey City

West Room, 13th floor

10:00 a.m.

Ocular Manifestations of Diabetes

Henry Abrams, M.D., Attending Ophthalmologist, Princeton Hospital, Princeton

Ocular manifestations of diabetes are listed as follows: Changes in refraction: (a) myopia may occur during acute onset or exacerbation of diabetes; (b) hyperopia may develop a few days after starting insulin therapy.

Weakness of accomodation.

Paralysis of ocular muscles—usually the abducens nerve is affected.

Changes in the iris.

Cataract formation is common.

Retinal changes: hemorrhages are usually round, of all sizes; exudates are waxy; proliferating retinopathy usually leads to blindness. Lipemia retinalis is a complication of diabetes which occurs when the lipoid content of the blood rises above 5 per cent.

10:30 a.m.

The Role of the Ophthalmologist in Ocular Complications of Diabetes

Robison D. Harley, M.D., Chief of Ophthalmology, Atlantic City Hospital, Atlantic City

Management of the ocular complications in diabetes mellitus demands the closest cooperation and interdependence of the ophthalmologist, diabetologist, and the patient. Few diseases run the gamut of complications in the eye and ocular adnexa as does diabetes. Brief mention of certain complications and the management will be enunciated. A representative group should include the following:

1. Refractive changes and weakness of accommodation.
2. Diabetic retinopathy.
3. Houssay phenomenon. Reversibility of diabetic retinopathy.
4. Cataract.
5. Iritis. Rubeosis irides.
6. Glaucoma.
7. Retinal vein thrombosis.
8. Ocular muscle neuropathy.
9. Optic nerve changes.

11:00 a.m.

Trends in Surgical Treatment of Vascular Lesions in Diabetes

Ralph Lev, M.D., Associate, Cardiovascular Surgery, Hunterdon Medical Center, Flemington; and Mercer Hospital, Trenton

A brief review of the patho-physiologic changes in the arterial system in diabetics is offered with special reference to the lower extremities. Plastic surgical treatments such as prosthetic direct and bypass arterial grafts and endarterectomy are explained and the indications and contraindications detailed. Clinical examples and methods of diagnosis, including roentgenography, aortography, and arteriography, and technics involved will be presented. Results of arterial surgery experienced by the author in diabetics and non-diabetics are compared.

11:30 a.m.

Management of Diabetes in the Patient with Visual, Renal and Neuropathic Complications

Pauline R. Goger. M.D., Assistant Director, Internal Medicine, Hunterdon Medical Center, Flemington

12:00 noon

General Discussion

12:15 p.m.

Business Meetings

NEUROPSYCHIATRY

Thomas S. P. Fitch, M.D., Chairman, Plainfield
William E. Ganss, M.D., Secretary, Plainfield

Card Room, Lobby floor

9:30 a.m.

The Role of the Division of Neurology, Seton Hall College of Medicine and Dentistry, Insofar As It Involves the Physicians of New Jersey

Joseph M. Foley, M.D., Chairman, Department of Neurology, Seton Hall College of Medicine, Jersey City

Discussor: Elic A. Denbo, M.D., Camden

This paper will explore the role of neurology in the modern teaching and practice of medicine. Like the nervous system it studies, neurology finds its way into and has a proper place in every organ and every system. The neurologist, probably more than any other specialist, feels isolated when too far away from the basic disciplines which are found in a medical school environment. It is hoped that the new Neurological Service will fill a need not only for neurologists but to all physicians who are neurologically oriented.

10:10 a.m.

The Role of the Full-Time Psychiatrist in the General Hospital Setting

Morris Parmet, M.D., Director, Psychiatric Services, Hunterdon Medical Center, Flemington

Discussor: Milton E. Kirkpatrick, M.D., Long Branch

Mental health concepts have a value in the care of all patients. The community health general hospital is expected to provide a wider range of services including those of mental health. This paper will point up how propinquity and availability of psychiatric care and thinking found its way into the structure and function of an entire Medical Center staff and the contributions it made to medical care and to meeting psychiatric needs of the community. Further evaluation is necessary to determine whether such a functional role has value in other settings.

10:45 a.m.

The Role of the Private Psychiatric Hospital in Meeting the Needs of the General Medical Community

Robert S. Garber, M.D., Medical Director, Carrier Clinic, Belle Mead

Discussor: William Furst, M.D., East Orange

The increasing awareness of emotional and mental illness has prompted many of our citizens to accept treatment much earlier than ever before. Consequently a private psychiatric hospital with higher personnel ratios is able to gear its therapeutic program for expediency thus enabling the patient to return to his home, family, and community in a relatively brief time. Actually, such programming meets the demands of a therapeutic community particularly when prepaid medical-surgical insurance plans underwrite the cost to the family.

11:20 a.m.

Business Meeting

OBSTETRICS AND GYNECOLOGY

EDWARD A. Y. SHELLENGER, M.D., Chairman, Camden
WILLIAM H. AINSLIE, M.D., Secretary, Metuchen

Tower Room, 13th floor

9:30 a.m.

Use and Abuse of Intravenous Oxytocin

Ralph H. Van Meter, M.D., Moorestown; Chief of Obstetrics and Gynecology, Burlington County Hospital, Mount Holly

Discussor: Douglas W. Payne, M.D., Asbury Park

The use of oxytocics from the pituitary gland spans nearly fifty years. During the first four decades, administration was by hypodermic injection; however the past ten years have seen the intravenous use of oxytocin. This technic provides finer control of the uterine contractions in obstetrics. As with any medication the limits of the agent must be recognized in order to provide safety to both the mother and infant. The contraindications if ignored are hazardous, but judicious use of the agent in suitably selected cases offers increased safety through careful management and supervision.

10:10 a.m.

Advances in Office Diagnosis in Gynecology

Joseph G. Stella, M.D., Associate in Obstetrics and Gynecology, Atlantic City Hospital, Atlantic City

Discussor: Emanuel R. Kant, M.D., Perth Amboy

The more recent advances in diagnostic methods which can be performed in the office are discussed. The technics are described together with their application to clinical problems such as vaginitis, ovarian dysfunction, infertility, pregnancy, and cervical malignancy. Studies of the cervical mucus, vaginal smear, and inspection of the cervix with the culposcope are considered in more detail with appropriate slides presented to illustrate the talk.

10:50 a.m.

Pelvic Cancer Problem—A Challenge to the Family Physician

John B. Montgomery, M.D., Professor of Obstetrics and Gynecology, and Co-Chairman of the Department, Jefferson Medical College, Philadelphia, Pa.

Discussor: Edward N. Bookrajian, M.D., North Bergen

Cancer is the second most frequent cause of death in the United States. In women more than one-fourth of all cancers develop in the pelvic organs and an equal number begin in the breast. Therefore, at least half of all cancers in women occur primarily in areas accessible to direct examination. In all of these areas, *early cancer is curable*. These facts present a real challenge to the family physician. This paper will present statistical evidence to justify the above statements and will discuss the technics of early diagnosis and other measures that will aid the physician to meet this challenge.

11:30 a.m.

Business Meeting

ORTHOPEDIC SURGERY

JOHN M. NAAME, M.D., Chairman, Atlantic City
ARTHUR S. THURM, M.D., Secretary, Trenton

Roberts Room, Chalfonte

10:00 a.m.

Symposium on the Injured Knee

Semilunar Cartilage Injuries

Robert V. Finnesey, M.D., South Orange; Clinical Assistant in Orthopedic Surgery, Orange Memorial Hospital, Orange

Discussion

10:25 a.m.

Fracture of the Patella

William J. D'Elia, M.D., Spring Lake; Attending in Orthopedics, Fitkin Memorial Hospital, Neptune

Discussion

In this age of rapid speed, injuries about the knee are progressively increasing, resulting in a high incidence of patella fractures. The patella, lying in the strong quadriceps tendon and situated in front of the knee, is constantly exposed to all forms of trauma, direct or indirect. The anatomic relationship, as well as the incidence and cause of patella fractures and associated soft tissue damage, are discussed. The diagnosis and treatment of the different types of patella injuries and the frequent residual complications are reviewed. The indications for conservative or operative care and the various forms of treatment and post-fracture care are presented.

10:50 a.m.

Strains and Sprains of the Knee Joint

William G. Kuhn, Jr., M.D., Attending in Traumatic Surgery, Orthopedics, and Fractures, St. Peter's General Hospital, and Middlesex General Hospital, New Brunswick

Discussor: John J. Flanagan, M.D., South Orange

Operative intervention for internal derangement of the knee joint is frequently recommended because of persisting pain, "giving way," and "locking" of the knee joint. Many times, no pathologic lesion is detected in the menisci or supporting ligaments of the joint. Too frequently, however, a meniscus must then be removed either because the surgical approach destroyed the normal attachment to the condyles of the tibia; or because of fear of the operating surgeon that a future tear of the meniscus may occur in a patient who has already undergone an arthrotomy. This discussion will point out the need for accurate differential diagnosis, and for proper management of the supporting structures of the knee immediately after injury. The similarity in symptoms and physical signs of a severe strain of the knee and a tear of one of the collateral ligaments or menisci is discussed. Immediate quadriceps setting and progressive resistance exercises establish an accurate differential diagnosis. These also prepare the patient for surgery if the eventual outcome is to be an arthrotomy.

11:15 a.m.

Arthritis of the Knee

Daniel R. DeMeo, Assistant in Orthopedic Surgery, Atlantic City Hospital, Atlantic City

Discussor: Jerome M. Cotler, M.D., Bridgeton

Osteoarthritis is a degenerative disease of joints. Many contributory factors are recognized, such as the wear and tear of advancing years, trauma and mechanical malalignment. Initially the degenerative process involves the articular cartilage. Incongruity of the joint surfaces results in friction, fibrillation and flaking of the articular cartilage. The synovium is in turn irritated and this reactive inflammation results in pain. The most commonly involved joint symptomatically is the knee. Treatment consists of rest, moist heat, salicylates and phenylbutazone. Intra-articular steroids have been very helpful but systemic steroids are rarely indicated.

11:40 a.m.

Business Meeting

12:30 p.m.

Luncheon—New Jersey Orthopaedic Society
Blue Room, Chalfonte

Reservations: John M. Naame, M.D.
1616 Pacific Avenue, Atlantic City

OTOLARYNGOLOGY

Joseph R. Burns, M.D., Chairman, Trenton
Myron J. Shapiro, M.D., Secretary, Newark

Room 1344, 13th floor

9:30 a.m.

Present Status of Stapes Mobilization

Robert F. Roh, M.D., Attending in Otolaryngology, East Orange General Hospital, East Orange

What does the present status of stapes mobilization permit the otologist to tell his patient with impaired hearing? Will the operation restore hearing to a practical level? Will the hearing improvement be permanent? Are there any dangers to the procedure? Could the hearing become worse? The presentation will include the surgical pathology encountered and its prediction from an analysis of the pre-operative audiogram; causes of failure; the complications occasionally seen; comments on the status of the fenestration operation and oval window surgery.

9:50 a.m.

Gamma Globulin in Otolaryngology

Louis E. Silcox, M.D., Professor of Otolaryngology, University of Pennsylvania Graduate School of Medicine, Philadelphia, Pa.

Chronic infection of the sinuses, ears, throat and lower respiratory tract may be due to a deficiency of gamma globulin. The causes of hypogammaglobulinemia and its effect on the respiratory tract as well as the results of a clinical study to stimulate the production of gamma globulin in the individual will be reviewed.

Tuesday Morning, May 17, 1960

10:15 a.m.

Panel Discussion: Indications and Contraindications for Tonsillectomy and Adenoidectomy

Moderator

Joseph R. Burns, M.D., Chairman, Section on Otolaryngology, Trenton

Panelists

Robert Forer, M.D., Attending Pediatrician, Mercer Hospital, Trenton

Francis S. Weinstein, M.D., Adjunct in Otolaryngology, Newark Beth Israel Hospital, Newark

Allan R. Shuster, M.D., Assistant in Ear, Nose, and Throat, Atlantic City Hospital, Atlantic City

The tonsils and adenoids should be removed whenever they are the seat or source of infection, tonsillitis, adenoiditis otitis media, either purulent or catarrhal, eustachian salpingitis, peritonsillar abscess or whenever the infected tonsils may be considered the focus of infection in cases of arthritis, and similar disorders. Contraindications are: acute respiratory infections, blood dyscrasias such as purpura, hemophilia, leukemia, severe anemia, uncontrolled diabetes, and acute stages of cardiac, liver and kidney diseases.

11:40 a.m.

Business Meeting

Tuesday Afternoon, May 17, 1960

MEDICINE

THOMAS M. KAIN, JR., M.D., Chairman, Camden
WILLIAM D. KIMLER, M.D., Secretary, Haddon Hgts.

Rutland Room, 1st floor

2:00 p.m.

Myocardial Infarction During Pregnancy

Randall S. Naden, Jr., M.D., Assistant in Medicine, Cooper Hospital, Camden

Co-Authors: Edwin N. Murray, M.D., Camden and Herbert F. Johnson, M.D., Camden

Discussor: Edward C. Klein, Jr., M.D., South Orange

The first case of proved myocardial infarction during pregnancy was reported in 1935. Since then, seventeen additional cases have been reported. The purpose of this paper is the presentation of an additional case, the nineteenth, and a review of the literature. Comparison of the occurrence, treatment and prognosis of myocardial infarction in the three trimesters of pregnancy is made.

2:30 p.m.

Reappraisal of Oral Hypoglycemic Agent

Edward F. Mazur, M.D., Associate in Medicine, Our Lady of Lourdes Hospital, Camden

Discussor: George A. Hess, M.D., Trenton

Five years ago medicine was excited by the introduction of a new mode of therapy for diabetes mellitus. Diabetes treatment had run through its various dietary fads before Banting and Best discovered insulin in 1921. This discovery added another triumph in alleviating a distressing physical disability. Oral therapy of diabetes had been the hope of many afflicted with the disease—also of clinicians and physiologists interested in this metabolic disorder. This new method has contributed to changing concepts, added to present management, stimulated new research, introduced new diagnostic technics. A comparison of the various oral hypoglycemic agents and their place in modern diabetes management is presented.

3:00 p.m.

The Incidence of Carcinoma of the Stomach in the Office Practice of Internal Medicine

Jacob L. Drossner, M.D., Attending in Medicine, Cooper Hospital, Camden

Discussor: William J. Snape, M.D., Camden

In eleven years, 363 patients were seen in the office with symptoms which called for upper gastrointestinal x-ray examination on 402 occasions. Carcinoma of the stomach was found in only three patients, the most recent of which was in December 1953. Since then, 267 patients underwent 270 roentgen examinations with not a single carcinoma of the stomach reported. The patients were predominantly middle-aged; all white; and in the middle and upper-middle income brackets. 62 per cent were Jewish. During the same ten-year period, the number of patients admitted to the Cooper Hospital with obvious carcinoma of the stomach declined 64 per cent.

3:30 p.m.

Clinical Evaluation of Hydrochlorothiazide

Bascom S. Waugh, M.D., Associate in Medicine, Cooper Hospital, Camden

Co-Authors: Thomas M. Kain, Jr., M.D., Camden and Lily Ruckstuhl, M.D., Camden

Discussor: Duncan Hutcheon, M.D., Jersey City

Thirty cases are presented. Twenty-five of them with edema, of which fifteen had congestive heart failure; four, nephrosis; five, cirrhosis with ascites; and one with edema of undetermined origin. There are five with hypertension. The cases are presented to show the diuretic effectiveness, as well as the antihypertensive action of the agent. The latter was demonstrated by combined therapy with other antihypertensive drugs in four of the five cases. The results are discussed and illustrated with the help of tables and graphs.

4:00 p.m.

Business Meeting

ALLERGY

HARRY H. HERSHEY, M.D., Chairman, Jersey City
AARON WEINER, M.D., Secretary, Fair Lawn

Mandarin Room, 13th floor

10:00 a.m.

Prophylaxis and Treatment of Insect Bite Allergy
Edward E. Seidmon, M.D., Plainfield; Chief of Allergy, Hunterdon Medical Center, Flemington

Discussion

The subject matter of this presentation deals with the classification of insect allergy, *Class*: Apis, *Genus*; Hymenoptera.

A study of thirty-five cases of bee and wasp sensitive patients will be reported. An outline will be offered for treatment by protein hyposensitization with bee and wasp venom for the protection of the sensitized patient.

10:30 a.m.

Present Concepts of Infectious vs. Allergic Rhinitis and Sinusitis

Walter A. Petryshyn, M.D., Director of Otolaryngology, Hunterdon Medical Center, Flemington

Discussion

Infectious and allergic rhinitis and sinusitis may produce similar symptoms and an accurate diagnosis must be made to treat the disease effectively. A thorough history, a rhinologic examination and special laboratory tests are necessary in the differential diagnosis. The development of the antibiotics, the antihistamines and more recently the corticosteroids has made significant changes in the treatment of these diseases.

11:00 a.m.

Hypnosis, Mental Health, and Allergis Disorders
Harold Rosen, M.D., Baltimore, Md.; Chairman, Committee on Hypnosis, American Medical Association, Chicago, Ill.

Discussion

11:45 a.m.

Business Meeting

ANESTHESIOLOGY

IRVING M. RIFFIN, M.D., Chairman, Montclair
ROBERT K. EGGE, M.D., Secretary, Newark

Tower Room, 13th floor

9:30 a.m.

Vesprin® Drip Post-Operatively

Ben Sheiner, M.D., Anesthesiologist, Pascack Valley Hospital, Westwood

Discussor: Gene L. D'Alessandro, M.D., Newark

A preliminary series of 100 patients were given Vesprin® in a dilution of 20 milligrams per 1000 cubic centimeters of 5 per cent glucose in water. This drip was administered intravenously during the immediate postoperative period. It was discovered that on awakening from their anesthesia, patients remained in a light sleep from which they were easily aroused. They could respond to questions giving coherent answers. Only one patient developed any immediate postoperative nausea, retching or vomiting. 76 per cent of the pa-

tients had amnesia for the first 12 hours postoperatively, 74 per cent had an alteration of their pain reception and required no narcotics during the first 6 hours. This group of 100 patients was compared with a control series.

9:50 a.m.

Obstetrical Anesthesia Coverage

George P. Potekhen, M.D., Senior Attending Anesthesiologist, Muhlenberg Hospital, Plainfield

Discussors: Durant K. Charleroy, M.D., Trenton and Herman I. Roseman, M.D., Glen Ridge

This paper is an attempt to show how the busy obstetrical service of Muhlenberg Hospital in Plainfield, is covered by a group of six anesthesiologists. The evolution of the growth in number, as well as complexity, of the coverage has brought forth the increasing responsibility of the anesthesiologists, and is presented with an attempt to emphasize the increasing importance of good, safe, and reliable anesthesia. A plea is made for more and more such coverage for the obstetrical patients as well as the surgical cases.

10:20 a.m.

Hypnosis in Office Practice

Paul C. Fagan, M.D., Bloomfield; Associate in Medicine, St. Vincent's Hospital, Montclair

10:45 a.m.

The Biochemistry of Central Nervous System Depressants

Milton Gross, Ph.D., Director, Department of Biochemistry, Margaret Hague Maternity Hospital, Jersey City

The mechanism of action of central nervous depressants will be discussed in the light of recent studies of brain metabolism, the application of electronic interpretation of brain activity, the increasing knowledge of the intimate functional structure of the brain, and the neurophysiology of the total pain complex. Such observations are making it possible to design more delicately selective depressants than those now available.

11:15 a.m.

Some Aspects of Anesthesiology in the Soviet Union

Emanuel M. Papper, M.D., Professor of Anesthesiology, Columbia-Presbyterian Medical Center, New York, N. Y.

This discussion will center upon the current status of anesthesiology in the Soviet Union, the plans for the future and the evolution of this specialty from the past. Particular emphasis will be placed upon clinical practices, training programs and research. Comparisons and contrasts with the United States and Great Britain will be described.

11:50 a.m.

Business Meeting

12:30 p.m.

Luncheon—Section on Anesthesiology
Zodiac B, Chalfonte

Reservations: Irving M. Riffin, M.D.
419 Park St., Upper Montclair

CHEST DISEASES

A. Aeram Peckman, M.D., Chairman, Jersey City
Saul Lieb, M.D., Secretary, Newark

West Room, 13th floor

10:00 a.m.

Symposium on the Medical-Legal Aspects of Cardiopulmonary Diseases

Pathology and Toxicology of Pneumoconiosis

G. W. H. Schepers, M.D., Haskell Laboratory and Toxicology for Industrial Medicine, Wilmington, Del.

Medico-legal aspects of pneumoconiosis pivot on proof and physical incapacitation. Etiologic agents exceed 3000, and new synthetic inhalants are constantly being introduced. Diagnosis has become almost wholly dependent on laboratory technics, except where epidemiologic evidence permits a presumption of causality. The following disciplines are invoked: optical microscopy, electron microscopy, spectrography, x-ray diffractometry, analytical chemistry, biochemistry. Experimental confirmation of pathogenicity is often mandatory. Pneumoconioses range from the indolent to the rapidly fatal. Disability emanates from impaired respiratory function, mediastinal and cardiac sequelae, infective and neoplastic complications and toxic involvement of extrathoracic organs. The following merit particular emphasis: interstitial fibrosis, alveolo-capillary block, emphysema, bronchiolar and bronchial impairment, vascular occlusion, tuberculosis, lung cancer, hepatic, renal, suprarenal and cerebral impairment.

Clinical Aspects of Industrial Diseases of the Lungs

Edgar Mayer, M.D., Clinical Professor of Industrial Medicine, New York University Post-Graduate Medical Center, New York, N. Y.

This discussion will emphasize adequate occupational history and clinical evaluation in order to establish criteria for partial and total impairment. Clinical and laboratory methods of disability evaluation will be discussed. The pneumoconioses to be considered will include those due to inhalation of inorganic particulate substances (dusts and fumes) of both mineral and metallic nature. Brief reference will be made to pulmonary diseases caused by the inhalation of organic particulate substances. Finally the related compensation aspects will be taken up.

Cardiac Disabilities

Arthur Bernstein, M.D., Chief, Heart Institute, United Hospitals of Newark

Injury to the heart may occur in two distinct ways, primarily while the worker is on the job. Essentially these are non-penetrating and penetrating injuries due to direct blows on the chest wall, abdomen or other parts of the body. A mechanism of their production, the trauma produced and the extent of injuries that may be expected as well as the electrocardiographic and x-ray findings, will be discussed. Damage to the heart as a result of "strain," both emotional and physical will be analyzed. The physiologic mechanisms of action that may produce this type of injury, physical findings, electrocardiographic data, x-ray findings and the question of total and permanent disabilities will be reviewed and discussed. Miscellaneous problems of aggravation of underlying heart disease and their relation to work will also be reviewed as time permits.

Legal Aspects

Roger W. Kelly, Esq., Supervising Deputy Director, Division of Workmen's Compensation, New Jersey State Department of Labor and Industry, Jersey City

The "Court's view" is discussed in evaluating factual and medical testimony in cardio-pulmonary disease cases arising from alleged occupational exposures and accidents. The effect of a recent decision by our N. J. State Supreme Court, will be analyzed with reference to the question of what constitutes an accident, bearing in mind the legal presumption that injury or death from heart disease is the result of natural physiologic causes. Also to be discussed are the implications of a case decided by the Appellate Division of our Superior Court, March 4, 1948, in which Certification was denied by the New Jersey Supreme Court. This case involved silicosis covering several employments with different employers. An intermediate employer was held responsible for full compensation benefits where inability to work came after claimant's causative exposure and for reasons not connected while working for a different employer.

11:00 a.m.

Panel Discussion

Moderator
Saul Lieb, M.D., Secretary on Chest Diseases, Newark

12:00 noon

Business Meeting

12:30 p.m.

Luncheon—New Jersey Chapter, American College of Chest Physicians

Parlor B. Chalfonte

Reservations: Emanuel Klosk, M.D.
46 Lyons Ave., Newark

GASTROENTEROLOGY AND PROCTOLOGY

HERBERT B. SILBERNER, M.D., Chairman, Newark
SAMUEL M. GILBERT, M.D., Secretary, Newark

Blue Room, Chalfonte

10:00 a.m.

Symposium on Constipation

Pathologic Physiology

Charles M. Lewis, M.D., Gastroenterologist, Barnert Memorial Hospital, Paterson; and Instructor in Medicine, Cornell University Medical College, New York, N. Y.

Constipation involves the entire neuro-muscular pathway from the bowel to the higher cerebral centers, (to say nothing of obstructing organic causes). An understanding of the mechanisms of

constipation is important in planning therapy. Functional causes remain the most common and the most resistant forms of constipation. Treatment is impossible, even in the hands of medical specialists, without an understanding of psychosomatic factors.

Psychosomatic Factors

Sanford M. Lewis, M.D., Director, Psychosomatic Clinic, Presbyterian Hospital, Newark

Constipation, in terms of physiologic equilibrium is absurd. It involves the retention of that for which there is no further use in the body economy. As a symptom of emotional conflict, however, it may echo a developmental stage in which colonic contents were the infant's only treasures. He could, in response to love or its absence, grant or deny. When disgust for his offerings replaced parental approval, he could omnipotently despoil or spare in proportion to his hostility. Clinically, a recognition of subconscious mechanisms for dealing with threatening life situations often provides the basis for symptom removal through appropriate psychotherapy.

Proctologic Aspects

Irving G. Larkey, M.D., Attending Proctologist, Irvington General Hospital, Irvington

This paper describes organic causes for constipation, as well as organic effects that can be brought on by functional constipation. Case histories are used to illustrate the various types of pathology encountered, as well as their sometimes far-reaching effects.

Clinical Approach to the Diagnosis and Treatment of Constipation

Herman Steinberg, M.D., Instructor in Medicine, Cornell University Medical College, New York, N. Y.

The *type* of constipation is determined clinically. Sigmoidoscopy and barium enema are often required to rule out organic lesions as well as to offer reassurance to both the patient and physician. Treatment of so-called "habit" or functional constipation includes a combination of reasurrance, descriptive explanation of mechanisms involved, conditioning and judicious use of external agents.

Symposium Discussor: Ferdinand G. Weisbrod, M.D., East Orange

12:00 noon

Business Meeting

GENERAL PRACTICE

Louis Kosminsky, M.D., Chairman, West New York
A. Guy Campo, M.D., Secretary, Westville

Roberts Room, Chalfonte

10:00 a.m.

Symposium on Geriatrics

Management of Disease of the Lower Bowel in Older People

Richard A. Hopping, M.D., East Orange; Attending Proctologist, Clara Maass Memorial Hospital, Belleville; and St. Barnabas Hospital, Newark

This paper offers an outline presentation of the approach to, the work-up, the treatment, and aftercare of the elderly patient with disease of the lower intestine.

Stay Alive—A Prophylactic Approach

Perry S. MacNeal, M.D., Chief, Department of Medicine, Pennsylvania Hospital, Philadelphia, Pa.

One of the important aspects of survival to a happy old age is the avoidance of the psychologic depression which so frequently accompanies the physical depression normal in advanced age. This should be planned for in advance and one's life lived in such a way that reserves of intellectual power, spiritual contentment, and friendly personal relations are available when needed.

General Discussion

11:45 a.m.

Business Meeting

PEDIATRICS

Milton M. Willner, M.D., Chairman, Newark
Samuel C. Southard, M.D., Secretary, Ventnor

Rutland Room, 1st floor

10:00 a.m.

Symposium on Retardation

The Problem of the Retarded Child

Lawrence B. Slobody, M.D., Professor of Pediatrics, New York Medical College, New York, N. Y.

Diagnosis of mental retardation is primarily a medical problem. Before any prescription can be given, many allied disciplines must test and interpret the child's functioning level and his potential, through physical, mental, social and emotional factors. Only in rare instances can mental retardation be helped by medical or surgical treatment. Parent guidance in the management of the retarded child is most important. Ultimately, the answer to mental retardation lies in prevention, achievable only through basic and applied research.

Pesudo-Retardation or Psychic Retardation

Bernard R. Goldberg, M.D., Newark; Medical Director, Guidance Clinic for Retarded Children, East Orange

In the past decade there has been an increasing awareness of the presence in the mentally retarded population of a large group (25 to 50 per cent) of atypical children who have in common these three signs: gross disturbance in motility, lack of empathy and severe loss of contact with reality. These may be present with or without evidence of so-called "organic neurologic disease" and give an early picture of the consequences of failure in ego development whether psychogenic or physiogenic. Symptomatic retardation is thus a symptom of the disease-psychosis. This emphasis, along with other recent developments further clarifies the group of retardates and sharpens the need for investigative and therapeutic measures.

Developmental Aspects of Retardation

Werner Kornfeld, M.D., Ph.D., East Orange; Research Associate, New York Medical College, New York, N. Y.

When parents become aware of an abnormality in the development of their child, they anxiously inquire about the outlook. Even in cases of predominant mental retardation, questions are not limited to the expected intellectual growth. The physician in charge of a retarded child has to familiarize himself with the connection between mental retardation and other developmental problems. This paper discusses the relation of mental deficiency to other facets of the child's development: physical growth, motor functions, nutritional problems, elimination control, sexual development, and social adjustment.

A Community Clinic for the Retarded

Mrs. Nellie Stone, Psychiatric Social Worker, Director, Guidance Clinic for Retarded Children, East Orange

Established in 1949 with the approval of the Essex County Medical Society, this Clinic was one of the first in the country to offer special diagnostic and guidance services to mentally retarded children and their parents. Operating through the clinical team process, medical, social and psychological examiners coordinate their conclusions into careful diagnostic classification and realistic social or educational planning. These findings are reported back to the referring physician for his use in continued medical treatment of the child, while the family is assisted by clinic staff to find and use appropriate community facilities for care, training and guidance. Medical direction is by a neuropsychiatrist, with pediatricians and other specialists serving as examiners. Full-time staff includes a caseworker and clinical psychologist, with a psychiatric social worker as administrator. The Clinic is supported by fees, on a sliding scale, as well as by community contributions and State Mental Health Act Funds. It is sponsored by the Essex Unit, New Jersey Association for Retarded Children. Last year over 400 children were served.

Symposium Discussor: Ralph N. Shapiro, M.D., West Orange

11:45 a.m.

Business Meeting

RADIOLOGY

C. Richard Weinberg, M.D., Chairman, Newark
John J. Thompson, M.D., Secretary, Montclair

Card Room, Lobby floor

10:00 a.m.

The New Jersey Radiologic Health Program

A. Investigation and Findings

B. Recommendations for Reducing Radiation Exposures

Roscoe H. Goeke, MBiorad, Acting Chief, Radiological Health Program, New Jersey State Department of Health, Trenton

Discussion

This presentation will outline the radiologic health program of the New Jersey State Department of Health, highlighting the Radiation Protection Act and the New Jersey Radiation Protection Code which should be enacted by early summer. Radiation hazards and methods for reducing both patient and operator exposure will be presented. The procedures in making the actual survey of an x-ray installation in a physician's office and the items that are monitored will be outlined. A list of commonly found defects and our recommendations for correcting them will be included.

11:00 a.m.

Recent Trends in Radiation Therapy of Breast Carcinoma

George P. Koeck, M.D., Director, Radiotherapy, Presbyterian Hospital Unit of United Hospitals of Newark

To administer proper radiotherapy to carcinoma of the breast, it is necessary to understand the disease and its natural course, with the many localized special characteristics of the anatomy, the lymphatic drainage and location of lymph nodes. The essentials of treatment include coverage of normal areas of disease plus the sites most frequently involved. Besides this, a definite dosage level rendered in a specific period of time is important for good therapy. With cobalt apparatus these conditions are most readily met with a resultant efficient tumorcidal dosage. Our methods of solving and applying these principles will be explained and depicted. The value of simple mastectomy plus adequate postoperative radiotherapy will be discussed in contrast to radical surgery alone or in combination with postoperative radiotherapy. A comparison of planning by orthovoltage methods with cobalt therapy will be made.

11:30 a.m.

Business Meeting

12:30 p.m.

Luncheon—Section on Radiology
Zodiac A. Chalfonte

Reservations: Austin J. Tidaback, M.D.
912 Prospect Ave., Plainfield

RHEUMATISM

Georgia E. Allen, M.D., Chairman, Haddon Heights
Jacob Heyman, M.D., Secretary, Newark

Room 1344, 13th floor

10:00 a.m.

Physical Medicine Modalities for Home Use for the Arthritic

Bertram M. Bernstein, M.D., Chairman, Department of Physical Medicine, Helene Fuld Hospital, Trenton; and Director, Department of Physical Medicine, Hunterdon Medical Center, Flemington

Adequate treatment of arthritis requires physical medicine. Because of the chronic nature of the arthritides, use of physical medicine modalities in the home constitutes a major part of the treatment regime and must be professionally supervised and prescribed. These modalities judiciously applied help prevent or lessen deformity, relieve symptoms and shorten the duration of the disease. However, to be effective, these modalities must be used daily or several times a day. There are numerous physical measures and many ways of utilizing each. Comments on the use of the various modalities will be given and slides will be used to demonstrate the various physical medicine modalities for home use in the arthritic.

10:20 a.m.

Panel Discussion: Cervical Osteoarthritis

Rheumatology

Herman H. Tillis, M.D., Associate in Arthritis, Presbyterian Hospital, Newark

Discussion of differential diagnosis of cervical osteoarthritis; also complete discussion of all forms of therapy—both medical and physical.

Orthopedics

James F. Collier, M.D., Haddonfield; Attending in Orthopedic Surgery, Cooper Hospital; and Associate in Orthopedic Surgery, Our Lady of Lourdes Hospital, Camden

Neurosurgery

Howard D. Medinets, M.D., Attending Neurosurgeon, Hackensack Hospital, Hackensack

11:00 a.m.

The Feet in Rheumatoid Arthritis

John J. Calabro, M.D., Assistant Professor of Medicine and Director, Division of Rheumatology, Seton Hall College of Medicine, Jersey City

Though much as been written about changes in the *hands* in rheumatoid arthritis, virtually little attention has been focussed on changes in the *feet*. Accordingly, the feet of rheumatoid arthritis patients were observed at the Jersey City Medical Center and were found to show characteristic rheumatoid features. These include: (1) generalized and symmetrical cock-up toes (hammer toes); (2) metatarsal head spread, prolapse and tenderness; (3) thickened and tender Achilles' tendons; (4) hallux valgus; and (5) corns, calluses, and bunions over bony prominences. Radiologic aspects are demonstrated with special stress on calcaneal and metatarsal osseous lesions, which may develop through stages of rarefaction, erosions, healing and spur formation.

11:20 a.m.

Surgical Rehabilitation for the Arthritic

Robert L. Preston, M.D., Associate Clinical Professor of Orthopedic Surgery, New York University Postgraduate School of Medicine, New York, N. Y.

Most patients with rheumatoid arthritis require a broad treatment program which includes systemic therapy as well as orthopedic treatment for the maintenance or restoration of musculoskeletal function. The foot and ankle often are involved in this disease. In any patient, it must be anticipated that severe foot or ankle disability probably will occur if the systemic disease remains active. In the early stage of the disease, prophylactic measures which can be applied by the physician who supervises the systemic treatment will minimize the development of severe deformities which will require surgical correction. The surgical and nonsurgical treatment of the foot and ankle lesions will be discussed.

11:50 a.m.

Business Meeting

12:30 p.m.

Luncheon—Section on Rheumatism
Parlor A, Chalfonte

Reservations: Jacob Heyman, M.D.
846 S. 12th St., Newark

UROLOGY

Reginald F. Seidel, M.D., Chairman, Englewood
Edward A. Brady, Jr., M.D., Secretary, N. Brunsw'k

Rowsley Room, 1st floor

10:00 a.m.

Infection and Renal Calculi

Hans H. Zinsser, M.D., Assistant Professor of Urology, Columbia University College of Physicians and Surgeons, New York, N. Y.

Stones in the urinary tract are often accompanied by infection. Sometimes the infection is a result of the partial obstruction caused by the stone; and in some instances the stones themselves are caused by the metabolic activities of the organisms. Over the past six years considerable success has been achieved with the prevention of recurrence of calculi produced by the second mechanism. The enzyme systems active in changing the precipitability of normal urinary components in the presence of infection are the urea splitting capacities of many of the Gram-negative and Gram-positive organisms, the citric acid splitting capacity and the capacity to split mucopolysaccharides. Stones caused by urea splitting mechanisms have been successfully attacked by the use of an oral mercurial diuretic which is an effective urease inhibitor. Infecting organisms are sometimes radically changed in sensitivity, usually for the better. There is good chance that this may be an effective adjunct to chemotherapy. The stones secondary to the enzymatic decarboxylations of citric acid in the urine are considerbaly less frequent than those due to urea splitting potentialities. They can be effectively blocked by small doses of fluoroacitate with actual enhancement of the citrate concentration in the urine and subsequent stone prevention.

The presence of abnormal neutral mucopolysaccharides in the urine of stone-forming patients has been adequately documented in the past year and a half by the use of new fractionation methods. The capacity of several species of bacteria to destroy useful protective mucopolysaccharides has been demonstrated. Antagonists such as sulfonated hesparadine give good promise of preventing this facet of bacterial action.

10:30 a.m.

Nephrotomography

Joseph V. Cusmano, M.D., Attending in Radiology, Englewood Hospital, Englewood

Nephrotomography is a radiologic procedure for accurately differentiating renal cysts and renal neoplasms. Following the rapid injection of 50 cubic centimeters of hypaque-90, films are exposed to show the renal arteries, followed by tomographic examination of the renal areas at multiple levels. The accuracy of the procedure is 95 per cent. It is useful in every case of renal mass, as an aid in pre-operative evaluation, resulting in more conservative surgery in the cases of renal cyst. In the aged and infirm, the information gained can avoid surgical intervention, when undesired, in the cases of renal cyst. Wide experience with nephrotomography at the Englewood Hospital, has shown its great accuracy and usefulness.

10:55 a.m.

Traumatic Rupture of the Kidney

George W. Irmisch, M.D., Chief of Urology, Helene Fuld Hospital, Trenton

Indirect force producing laceration of the kidney has been described especially in athletes who are playing baseball or swinging and missing golf balls. Occasionally men who do heavy work or

lifting, suffer a laceration of the kidney with subsequent hematuria. Commonly, these kidneys are not normal, but present some pathologic condition. The patient presented in this paper had a profound anemia, and complained of loin pain. The diagnostic procedures are demonstrated roentgenographically and illustrate an unusual diagnostic problem.

11:20 a.m.

Rupture of the Urinary Bladder

Herbert D. Axilrod, M.D., Chief of Urology, Atlantic City Hospital, Atlantic City

The types, etiologic factors, treatment, and sequelae of rupture of the urinary bladder are discussed. Illustrative cases will be presented.

11:45 a.m.

Business Meeting

12:30 p.m.

Luncheon—Section on Urology
Bakewell Room, 1st floor

Reservations: Reginald F. Seidel, M.D.
214 Engle St., Englewood

SURGERY

Paul Mecray, Jr., Chairman, Camden
Eugene L. Watkins, M.D., Secretary, Morristown

Rutland Room, 1st floor

12:30 p.m.

Luncheon—Section on Surgery, and New Jersey Chapter, American College of Surgeons
Wedgwood II, Lounge floor

Reservations: Robert N. Bowen, M.D.
South Jersey Medical Center, Route 70, Haddonfield

2:00 p.m.

Current Surgical Research and its Implication for Clinical Surgery

John H. Grindlay, M.D., Chief, Section of Surgical Research, Mayo Clinic, Rochester, Minn.

2:30 p.m.

Round Table Discussion: Revascularization of the Lower Extremity with Arterial Insufficiency

Moderator

John H. Caputi, M.D., Associate in General Surgery, Cooper Hospital, Camden

E. Bruce Hallett, M.D., Assistant Associate in General Surgery, Morristown Memorial Hospital, Morristown

George F. Hewson, M.D., Attending Surgeon, Presbyterian Hospital, Newark

Norman Rosenberg, M.D., Highland Park; Director of Vascular Diseases, Middlesex General Hospital; and Senior Attending Surgeon, St. Peter's General Hospital, New Brunswick

Victor Parsonnet, M.D., Adjunct in Surgery, Newark Beth Israel Hospital, Newark

With the increasing age of the general population, the prevalence of atherosclerosis in our society, and the concurrence of metabolic diseases the patient with arterial insufficiency is appearing with more frequency. Problems of diagnosis, patient selection, and surgical therapy will be discussed.

3:30 p.m.

Business Meeting

House of Delegates

President, F. Clyde Bowers, M.D., Mendham

Secretary, Marcus H. Greifinger, M.D., Newark

Parliamentarian, Robert M. Backes, Trenton

The Committee on Credentials will meet at the Registration Desk each morning of the meeting.

Viking Room, 13th floor

SESSIONS

First Session: 2:30 p.m., Saturday Afternoon, May 14, 1960

1. Call to Order
2. Invocation
   Reverend Robert Burns, Hilltop Presbyterian Church, Mendham, New Jersey
3. Organization of the House
4. Transactions of 1959 Annual Meeting
5. Introduction of Guests and Delegates from Other States
6. Annual and Supplemental Reports
7. Resolutions
8. New Business
9. Announcements

Second Session: 2:30 p.m., Sunday Afternoon, May 15, 1960

1. Report of Nominating Committee
2. Election

Third Session: 9:30 a.m., Monday Morning, May 16, 1960

1. Reports of Reference Committees
2. Unfinished Business
3. Installation of Incoming President
4. Adjournment

Reference Committees

Sunday Morning, May 15, 1960

11:00 a.m.

Reference Committee "A"

Room 1333, 13th floor

Reports of the:

- President
- Board of Trustees
- Secretary
- Judicial Council
- Executive Officer

Reference Committee "B"

Room 1344, 13th floor

Reports of the:

- Treasurer
- Committee on Finance and Budget
- Committee on Publication
- Committee on Medical Student Loan Fund

Reference Committee "C"

Mandarin Room, 13th floor

Reports of the:

- Medical Service Administration of New Jersey
- Medical-Surgical Plan of New Jersey

Reference Committee "D"

Room 1335, 13th floor

Reports of the:

- Committee on Medical Education
- Committee on Medical Defense and Insurance
- Special Committee on Physicians Placement Service
- Special Committee on Retirement Plan for Physicians

Reference Committee "E"

Room 1337, 13th floor

Reports of the:

- Council on Legislation
- Council on Medical Services
  and its Special Committees on:
  - Industrial Health
  - Workmen's Compensation
- Council on Public Relations

Reference Committee "F"

Rowsley Room, 1st floor

Reports of the:

- Council on Public Health
  and its Special Committees on:
  - Cancer Control
  - Child Health
  - Chronically Ill and the Aging
  - Conservation of Hearing and Speech
  - Maternal and Infant Welfare
  - Mental Health
  - Rehabilitation
  - Conservation of Vision
- Special Committee on Disaster Medical Services
- Special Committee on Traffic Safety

Reference Committee "G"

Room 1332, 13th floor

Reports of the:

- Committee on Annual Meeting
  and its Subcommittees on:
  - Scientific Exhibit
  - Scientific Program
- Advisory Committee to Woman's Auxiliary
- Committee on Credentials
- Nominations for Honorary Membership
- Nominations for Emeritus Membership

Reference Committee on Constitution and Bylaws

Bakewell Room, 1st floor

Report of the:

- Committee on Revision of Constitution and Bylaws
- Amendments to the Constitution
- Amendments to the Bylaws

Reference Comittee on Credentials will meet at the Registration Desk each morning of the meeting.

33rd Annual Meeting

Woman's Auxiliary to The Medical Society of New Jersey

MAY 14 - 17, 1960

Mrs. Samuel L. Kaman, Chairman

Mrs. Anthony G. Merendino, Co-Chairman

Daily Schedule

Saturday, May 14, 1960

10:00 a.m.—Registration Opens
Lobby floor, Haddon Hall

1:00 p.m.—Coffee served until 3:00 p.m.
Hospitality Lounge, Lobby floor, Haddon Hall

3:00 p.m.—Bingo until 4:00 p.m.
Music Room, Lounge floor, Chalfonte

3:30 p.m.—Golden Merit Award Ceremony
Viking Room, 13th floor

Sunday, May 15, 1960

9:00 a.m.—Registration—Breakfast and Luncheon Tickets
Lobby floor, Haddon Hall

Dinner Tickets
Sun Porch, Lounge floor, Haddon Hall

Coffee served until 11:00 a.m.
Hospitality Lounge, Lobby floor, Haddon Hall

12:30 p.m.—Pre-Convention Meeting of the Executive Board
Pavilion, 15th floor, Haddon Hall

1:00 p.m.—Art Exhibit opens: County Press and Publicity Book Exhibit
Lobby floor, Haddon Hall

2:00 p.m.—Tea and Fashion Show in honor of Fellowettes
Rutland Room, First floor, Haddon Hall

6:30 p.m.—Fellowettes' Dinner
Bakewell Room, First floor, Haddon Hall

Monday, May 16, 1960

8:30 a.m.—Registration
Lobby floor, Haddon Hall

9:00 a.m.—Breakfast and Luncheon Tickets
Lobby floor, Haddon Hall

Dinner Tickets
Sun Porch, Lounge floor, Haddon Hall

9:00 a.m.—Coffee served until 11:00 a.m.
Hospitality Lounge, Lobby floor, Haddon Hall

General Session
Rutland Room, First floor, Haddon Hall

12:30 p.m.—Luncheon
Carolina Room, Lounge floor, Chalfonte

2:30 p.m.—General Session (reconvenes)
Rutland Room, First floor, Haddon Hall

2:30 p.m.—Bus trip (Entertainment for non-Auxiliary doctors' wives who will not be attending the General Session)

3:00 p.m.—General Session of the 194th Annual Meeting of The Medical Society of New Jersey. Members of the Woman's Auxiliary are invited to attend.
Viking Room, 13th floor, Haddon Hall

9:00 p.m.—Music and Dancing
Rutland Room, First floor, Haddon Hall

Tuesday, May 17, 1960

8:45 a.m.—Inaugural Breakfast
Music Room, Lounge floor, Chalfonte

9:00 a.m.—Registration
Lobby floor, Haddon Hall

9:00 a.m.—Golf Tournament
Linwood Country Club

10:00 a.m.—Post-Convention Board Meeting
Music Room, Lounge floor, Chalfonte

11:45 a.m.—President's meeting for Incoming County Presidents
Music Room, Lounge floor, Chalfonte

2:00 p.m.—Tea and Informal Discussion on Art Exhibit
Lobby floor, Haddon Hall

7:00 p.m.—Dinner-Dance
Carolina Room, Lounge floor, Chalfonte

Scientific Exhibits

Garden and Vernon Rooms, Lounge floor

Exhibit Hours: 1:00 p.m. - 5:00 p.m., Sunday, May 15, 1960
9:00 a.m. - 5:00 p.m., Monday and Tuesday, May 16 and 17, 1960
9:00 a.m. - 1:00 p.m., Wednesday, May 18, 1960

Booth 1. Treatment of Anxiety-Depressive Reactions in General Practice—Harold S. Orchow, M.D., Palmyra

Proper therapy for patients with symptoms of both anxiety and depression is the subject of this exhibit. Because of the frequency with which mixed symptoms occur, a combination of a new anti-depressant drug and a tranquilizer was studied in 80 such patients. The usefulness of the drug depends upon safety as well as efficacy. Attention is, therefore, paid to the side reactions sometimes produced by other monoamine oxidase inhibitors and phenothiazines. Clinical observations, standing blood pressures, EKG, and blood counts are presented. Based upon these observations, an evaluation of the usefulness of the drug in everyday practice is attempted.

Booth 2. Total Approach to the Management of Senile Agitation—Edward Settel, M.D., Forest Hills Nursing and Rehabilitation Center, Brooklyn, N. Y.

The rapidly increasing geriatric population, with its attendant emotional and medical disorders presents a complex problem. This presents a study of senile patients, demonstrating various states of agitation, disorientation, retardation, and in some cases, incontinence. These chronic brain syndromes were controlled in our institution and later managed at home. An established regimen, combining psychotherapy, occupational therapy, and drug therapy has been developed. By controlling the patients' hyperexcitability through the use of drug therapy, they became amenable to psychotherapy and occupational therapy. Under this program the patient acquires a degree of self-sufficiency that enables him to become integrated within the normal family environment.

Booth 3. Management of Insomnia—Oscar Rozett, M.D., Fair Oaks Hospital, Inc., Summit

An exhibit on management of insomnia with emphasis on treatment of underlying cause (anxiety, etc.). Clinical documentation will review over 100 cases. Included is a historical review of drug therapy culminating in combined use of an anti-anxiety agent with a hypnotic agent. Pharmacologic data will show potentiation action.

Booth 4. Diagnosis in Patients with Stroke—Robert A. Kuhn, M.D., Division of Neurosurgery, Department of Surgery, All Souls Hospital, Morristown

Illuminated, flush-mounted panels show sequential cerebral angiograms in six patients with cerebrovascular accidents. Patterns of filling and emptying are demonstrated for each upper thorax-cervical-cerebral circulation by three views in the lateral and three in the occipital projections. Side by side with each film in these series is a line-drawing diagramming the circulatory anatomy opacified in that particular radiogram. Sequences show different cervical and intracranial angiographic abnormalities responsible for ordinary types of "strokes." Pre-angiographic clinical differential diagnosis failed in each instance to identify the specific causative lesions.

Booth 5. A Study of Organic Disease in Psychiatric Patients—Thomas J. White, M.D., Martin W. Pollini, M.D., Nathan Frank, M.D., Sylvester Choffy, M.D., and G. Thomas DeFusco, M.D., Hudson County Hospital for Mental Diseases, Secaucus

This exhibit highlights the co-existence of organic diseases such as tuberculosis, heart disease, hypertension, obesity, and others found in psychiatric disorders. A thousand charts in a psychiatric hospital have been reviewed, and the results presented.

Booth 6. New Horizons in Parkinson Therapy—Lewis J. Doshay, M.D., Columbia-Presbyterian Medical Center, New York, N. Y.

The exhibit summarizes experiences with thousands of patients over a period of 30 years. Attention is given to newer medications. Emphasis is placed upon the three essentials of therapy and the need for full orientation of the patient. Advances in the neurosurgery of Parkinson's disease are presented. Charts illustrate how *exogenous* toxins produce Parkinson symptoms in normal people and how these may bridge the gap to the identity of the *endogenous* toxins responsible for Parkinson's disease and may ultimately lead to the discovery of an antidote that will prevent or arrest the progress of the disease. The frontiers of Parkinson therapy have expanded materially since 30 years ago and the outlook for the future is brighter.

Booth 7. Surgical Management of Aortic Stenosis—Robert P. Glover, M.D., Julio C. Davila, M.D., and Robert G. Trout, M.D., Presbyterian Hospital, Department of Thoracic and Cardiovascular Surgery, Philadelphia, Pa.

The problems inherent in the management of aortic stenosis are far more serious than those encountered in the management of mitral obstruction. Since the beginning of intracardiac valvular surgery there have been many variations in approach to the aortic valve. This exhibit presents the evolution of a single basic technic from its inception to the present time, including a workable diagnostic guide for the proper selection of possible surgical cases, and a short film strip to illustrate the inherent problems in the disease process and the technics and results employed at the present time in surgical correction.

Booth 8. Mechanisms and Therapy of Congestive Heart Failure—William Likoff, M.D., Hahnemann Medical College and Hospital, Cardiovascular Section, Philadelphia, Pa.

The first portion of this exhibit is concerned with the functional physiologic and anatomic aspects of congestive heart failure. The second portion of the exhibit presents the therapy, specifically personal work done with the use of hydrochlorothiazide.

Booth 9. Simplified Diagnosis for Cardiovascular Surgery—Ralph Lev, M.D., and Lucy Aiello, M.T., St. Peter's Hospital, New Brunswick; Mercer Hospital, Trenton; Hunterdon Medical Center, Flemington; and Princeton Hospital, Princeton

This exhibit indicates the simplified methods now available for an accurate diagnosis of cardiovascular diseases and their amenability to cardiovascular surgery. Equipment used for dye dilution curves, ear and cuvette oximetric determination of blood oxygen saturation, phonocardiography and angio-cardiography will be demonstrated. Details of the technics employed will be outlined and clinical examples as observed in everyday practice in either the university or community hospital will be cited. Application of this data in the recommendation for or against cardiovascular surgery is indicated.

Booth 10. Open Heart Surgery at the Passaic General Hospital—Theodore K. Keith, M.D., Dryden P. Morse, M.D., Michael Remondo, M.D., Daniel Downing, M.D., F. Albert Graeter, M.D., William Cantwell, M.D., Nathan Nussbaum, M.D., and Lawrence E. Batlan, M.D., Passaic General Hospital, Passaic

The exhibit illustrates the development and accomplishment of the open correction of congenital and acquired heart lesions at the Passaic County Cardiovascular Unit. In the past year the following congenital defects have been corrected under direct vision without mortality: ventricular septal defects; atrial septal defects; pulmonic stenosis; congenital aortic stenosis and atrioventricularis communis. The new technics for the surgical correction of these lesions by the use of extracorporeal circulation, with a pump-oxygenator and heat exchanger are illustrated. Particular emphasis is placed on the use of deep hypothermia (below 70 degrees F.) in conjunction with extracorporeal circulation to achieve a quiet, bloodless heart for the repair of the more complex lesions. Film strips, representative x-rays, electrocardiograms and phonocardiograms before, during and after surgery are presented. Charts, diagrams, drawings and photographs are also used throughout the presentation.

Booth 11. Shock and Arrhythmias: Their Management—Arthur Bernstein, M.D., Franklin Simon, M.D., Jerome G. Kaufman, M.D., Frederick B. Cohen, M.D., Bernard Robins, M.D., and Edwin L. Rothfield, M.D., Newark Beth Israel Hospital, Newark

The treatment of shock, particularly that accompanying myocardial infarction, has been beset with many problems and complications. A new practical management of shock in myocardial infarction and other conditions utilizing physiologic concepts is presented. A new approach to the treatment of certain cardiac arrhythmias is described with illustrative cases and pertinent electrocardiograms.

Booth 12. The Handicapped Child—E. Milton Staub, M.D., T. Campbell Thompson, M.D., Francis J. Fadden, Jr., M.D., Catherine Spears, M.D., and Charles I. Nadel, M.D., Children's Country Home, Westfield

The purpose of the exhibit is to show activities at Children's Country Home for the handicapped child with special emphasis on those afflicted with cerebral palsy; some methods of therapy and also the results of newer muscle-relaxants and sedatives used for the cerebral palsy child will be demonstrated.

Booth 13—Visible Speech—Hearing and Speech Center, Newark Eye and Ear Infirmary, United Hospitals of Newark; and Division of Chronic Illness Control, New Jersey State Department of Health, Trenton

This exhibit will illustrate recorded speech of hearing and speech handicapped individuals—laryngectomies, congenital deaf, hard of hearing, stutterers, aphasics, etc. Instrumentation will be utilized to record and demonstrate means utilized in studying phonetic structure of speech phonation.

Booth 14. Orthoptics—Department of Visual Rehabilitation, Newark Eye and Ear Infirmary, United Hospitals of Newark; and Division of Chronic Illness Control, New Jersey State Department of Health, Trenton

This exhibit demonstrates the usage of orthoptics as a pre- and post-medical technic in the study and care of muscle eye deviations.

Booth 15. Stapes Surgery for Otosclerotic Deafness—I. M. Schnee, M.D., Barnert Memorial Hospital, Paterson

Stapes mobilization for otosclerotic deafness as introduced by Rosen results in thirty per cent successful cases. With application of greater magnification (operating microscope) additional procedures were developed to increase the percentage of successful cases. These procedures are anterior crurotomy, transposition of crura, polyethylene substitution, fenestration of footplate and vein graft. Photomicrographs, charts, sketches, dissected human specimens will depict the anatomy, pathology and technic of these procedures. Statistical data of 150-200 documented cases will be given, showing age, sex, duration, pre-operative and postoperative hearing levels.

Booth 16. Manifestations of Muscular Dystrophy—Ade T. Milhorat, M.D., Institute for Muscle Disease, New York, N. Y.

The exhibit presents the manifestations of muscular dystrophy, postural changes and characteristics of the early and advance stages of progressive muscular dystrophy, and color transparencies of personnel engaged in various MDAA-sponsored research projects under the grants-in-aid program. An automatic play-back tape features an informational interview with Dr. J. Morrison Brady, Medical Director, M.D.A.A., Inc.

Booth 17. Expanding Frontiers of Cytology—Howard B. Miller, M.D., New Jersey Cytology Center, Fair Lawn; and Cytology Division, Board of Health, Paterson

1. Newest advances in cytology. 2. Demonstration of cytologic technics, methods, and results. 3. Demonstration of actual microscopic set-ups, as well as charts, etc. 4. Conclusions: Cytology is increasing in importance as a means of detecting early carcinomas and should be used to a greater extent.

Booth 18. Nephrotomography—Joseph V. Cusmano, M.D., Department of Radiology; and Reginald F. Seidel, M.D., Department of Urology; Englewood Hospital, Englewood

Nephrotomography is a radiologic procedure for accurately differentiating between renal cysts and renal neoplasms. Developed by Dr. John Evans, at The New York Hospital-Cornell Medical Center, this procedure is readily performed at the community hospital level. The exhibit consists of roentgenograms of typical, illustrative cases, discussing the technic, and interpretation of the results. Wide experience with this procedure at the Englewood Hospital illustrates the great usefulness, and accuracy of nephrotomography.

Booth 19. A Community Blood Bank in Action—Bergen Community Blood Bank, Paramus

This exhibit is to show the doctors how blood could be more available in their areas. We have many requests for material on this bank and felt that this exhibit would be of much value to all since it would give a picture of how one could be started and also have a source of information for anyone who would wish to start a community blood bank. It would be shown how to organize donor clubs, and other problems that arise in blood banking such as the negative situation. (Sponsored by the Bergen County Medical Society)

Booth 20. Diseases of the Digestive Tract in Natural Color—Martin R. Rush, M.D., Aldo G. Baldi, M.D., and Eugene Tchekunow, M.D., Monmouth Medical Center, Long Branch

A broad spectrum review of pathology of the digestive tract with a pathologist in attendance to present the clinical data and discuss possible causal relationship between benign and neoplastic disease. In order to avoid a didactic presentation of specimens, emphasis will be placed on the clinicopathologic correlation of the available material. Demonstrations of the color restoration technic will be held daily for anyone who may be interested in this aspect of the exhibit.

Booth 21. Management of the Obese Diabetic—S. K. Fineberg, M.D., Harlem Hospital, New York, N. Y.

Obesity associated with diabetes is the rule particularly in the mild, maturity-onset form. There is an unfortunate tendency to treat such patients with oral hypoglycemics, because of convenience, and to neglect dietary measures. Weight reduction will ameliorate both obesity and diabetes. 54 patients completed a double-blind study with phenmetrazine hydrochloride and placebo without knowledge of the purpose of therapy. Illustrative charts are exhibited. Seventy-two per cent of patients on phenmetrazine lost weight significantly. Fifty per cent of insulin-taking diabetics stopped insulin or reduced dosage 50 per cent or more. Treatment with anorexigenic agents plus diet is preferable to indiscriminate use of oral hypoglycemics in obesity-diabetics.

Booth 22. The Gastroenterologist at Work—New Jersey Gastroenterological Society

The various clinical, investigative, and therapeutic procedures performed by the gastroenterologist are described and illustrated. These include the clinical story, physical examination; endoscopy (sigmoidoscopy, esophagoscopy, gastroscopy); laboratory investigation, particularly those procedures relating to qualitative and quantitative study of the secretions of the gastrointestinal systems (gastric analysis, tube and tubeless, biliary studies, secretin test); cytologic studies (esophagoscopic, gastric, biliary, rectal) and finally roentgen examination. Any or all of these procedures, including endoscopy, will be available to those physicians who request an examination during the exhibition.

Booth 23. The Comparative Clinical Pharmacology and Effectiveness of the Newer Corticoids—Herbert S. Kupperman, M.D., and Jeanne A. Epstein, M.D., New York University-Bellevue Medical Center, Department of Therapeutics, New York, N. Y.

The avalanche of new corticoids confronting the practicing physician makes it essential to determine the comparative activity of these corticoids with respect to specific pharmacologic action. The effect of the corticoids upon carbohydrate tolerance will be described, comparing aldosterone, cortisone, hydrocortisone, prednisolone, prednisone, 6-methyl-prednisolone, triamcinolone, dexamethasone, and fluorocortone. The response of the patient to insulin under the influence of these corticoids will be discussed. The effect of the corticoids upon inhibition of pituitary ACTH, thyrotropic stimulating hormone, melanophoric stimulating hormone, and anti-diuretic hormone will be described with the compartive activity of the different compounds being listed. The relative activity of the compounds in producing alteration in water and electrolyte metabolism will be noted and compared with the standard compounds, desoxycorticosterone acetate and aldosterone. A summary of the specific effects of corticoids upon various biological functions, including their effect upon hair growth and gonadal function will be listed in a comparative form and classified according to their relative activity.

Booth 24. Propionyl Erythromycin—Laboratory and Clinical Considerations—R. S. Griffith, M.D., Marion County General Hospital, Indianapolis, Ind.

Clinical studies have been performed comparing the increased absorption and delayed excretion of propionyl erythromycin with other forms of erythromycin. This has been demonstrated also with comparative blood levels of different forms of erythromycin. The results of these studies are verified by demonstration of higher levels of the propionyl ester of erythromycin when compared to other forms. Charts are used to illustrate the variation in biliary excretion of different forms of erythromycin and blood levels of various erythromycin preparations. Tables demonstrating clinical results of various types of infections are included in the exhibit.

Booth 25. Congeners in Whiskey—Institute of Public Information, New York, N. Y.

Congeners (fusel, oil, aldehydes, acids, etc.) are substances found in alcoholic beverages that provide their taste, bouquet, and color. In large amounts, however, congeners may produce toxic or irritating reactions. This exhibit presents the results of quantitative chemical analyses of congeners found in six leading types of distilled spirits along with correlated acute oral toxicity studies obtained on rats and irritation studies using the rabbit eye technic. Pertinent literature will be available.

Booth 26. Triclobisonium Chloride in Dermatologic Therapy—John A. Hunt, M.D., and Bart M. James, M.D., East Orange

A review of medical histories reveals that the incidence of bacterial skin infections has not decreased. There is, as yet, no practical means of making the skin sterile. A broad spectrum antimicrobial is required in infectious dermatoses. Of 249 bacterial cultures, 80 per cent of the skin infections were due to staphylococcus aureus. The study was done to determine the effectiveness of a new topical microbicide in primary skin infections. Ninety-two per cent of patients with primary pyodermas were cured or improved, and 87 per cent of 136 patients with steroid responsive infected dermatoses had effective results. Triclobisonium chloride may be used effectively to treat common dermatologic conditions seen in everyday practice.

Booth 27. Hemoperfusion for Hepatic Coma—Thomas F. Nealon, Jr., M.D., Herbert Cohn, M.D., and John H. Gibbon, Jr., M.D., Jefferson Medical College, Philadelphia, Pa.

It is the purpose of this exhibit to describe a new method of treating ammonia intoxication and its resultant neurologic syndrome of hepatic coma. This utilizes passage of the patient's blood directly over ion exchange resins in a plastic pack. The resin then sequesters ammonia in exchange for sodium. Laboratory experiments and clinical application will be presented.

Booth 28. Systemic Corticosteroid Therapy in Dermatoses—Herbert A. Luscombe, M.D., and Harold L. Colburn, M.D., Jefferson Medical College Hospital, Philadelphia, Pa.

This scientific exhibit consists of illuminated before and after transparencies indicating the clinical evaluation of dexamethasone in various dermatoses.

Booth 29. Virus-Caused Neurologic Disease in New Jersey—1959—Martin Goldfield, M.D., Division of Laboratories, New Jersey State Department of Health, Trenton

Laboratory methods demonstrated for use in establishing evidence for diagnosis by (1) virus isolation, (2) serologic tests, (3) pathologic study of tissues. Clinical manifestations of neurologic illnesses of virus origin most frequently do not permit specific diagnoses. Laboratory results must be relied upon for final diagnosis and verification and to carry out epidemiologic control of these diseases. The incidence of Coxsackie, Echo, polio and Eastern Encephalitis virus infections will be illustrated.

Booth 30. Non-Surgical Treatment of Cholelithiasis with Observations on Cholecystitis and Liver Diseases—Jacob A. Riese, M.D., Jersey City Medical Center, Jersey City

This is a clinical study of 122 cases of cholelithiasis, cholecystitis, biliary tract disorders, liver disease followed for a period of nine months or longer and treated with D-Clucitol, placebos, diet, and other drugs. Graphs, case histories, x-ray films and other visual material will illustrate results obtained medically, and a number of cases requiring surgery.

Booth 31. Maxillo Facial Rehabilitation—Michael L. Lewin, M.D., and Eugene Gottlieb, M.D., Paterson

This exhibit deals with congenital and acquired deformities of the jaws associated with functional disruption and cosmetic deformities. Various corrective surgical procedures associated with dental restoration are demonstrated. The result provides satisfactory jaw function and restores normal esthetic appearance.

Booth 32. Methohexital Sodium—A New Induction Anesthetic—Irving M. Riffin, M.D., St. Vincent's Hospital, Upper Montclair

The evaluation of methohexital in 500 patients will be presented. EKG, EEG and pneumotachograph studies will be shown. The pharmacology of the new drug in relation to thiopental sodium and thiamylal sodium will be demonstrated. Of particular interest is its rapidity of metabolism in the body and its greater potency, i.e., one-fifth to one sixth of the milligram dose is used for induction.

Booth 33. Presacral Neurectomy in Dysmenorrhea and Obstetrics—William A. Anderson, M.D., Bloomfield, and Carl F. Buechle, M.D., East Orange

This is designed to show the benefits of a presacral neurectomy in the treatment of painful menstruation and the painless first stages of labor in those women who have had this operation. Statistics will show some 61 cases performed by Anderson and some 11 cases delivered by Buechle. Technic will be shown by colored photographs.

Booth 34. Neonatal Surgical Emergencies—Richard C. Reed, M.D., and Celestino Clemente, M.D., The United Hospitals of Newark—Babies Hospital Unit, Newark

Early recognition and early treatment of neonatal surgical emergencies are fundamental to improve the survival rate of newborns with congenital anomalies incompatible with life.

Booth 35. A Simplified Technic for Intestinal Anastomosis—John A. Sakson, M.D., Trenton

This exhibit demonstrates a different type of intestinal anastomosis which is applicable to all areas of bowel. It illustrates in a simplified manner the basic principle involved in a segment of small intestine, with each step explained in detail. Also shown is the manner in which the same procedure is used in anastomosing small bowel to large bowel; colon to colon; and the simple and rapid method of measuring bowel lumens of unequal size to produce the desired union. The advantages of this method are: 1. It combines the best features both side-to-side and end-to-end anastomoses, with none of the undesirable ones. 2. It is simple, rapid and leak-proof. 3. It produces a diagonal suture line which resists stenosis and obstruction.

Booth 36—Skin Homografts Exchanged Between Parents and Their Children—Lyndon A. Peer, M.D., Iqbal S. Walia, M.D., and John C. Walker, Jr., M.D., St. Barnabas Medical Center, Newark

The behavior of skin homografts exchanged between parents and their children will be shown by illustrations and figures. Grafts exchanged between fathers and their children were all rejected by 14 days. Skin homografts exchanged between mothers and their children evidenced a long-survival time in about 25 per cent of the cases. This survival time ranged from 30 days to 3 years and some of the grafts are still surviving. Evidence of survival, other than gross examination, has been made by sex chromatin study from biopsies of the skin homografts when skin exchanges were made between opposite sexes.

Booth 37. Closure of Skin Incisions Without Sutures—Theodore Golden, M.D., Albert H. Levy, M.D., and Dean A. Wry, M.D., Veterans Administration Hospital, East Orange; and St. Vincent's Hospital, New York, N. Y.

A four panel exhibit. A report on clinical and experimental studies on skin approximation of surgical incisions and wounds, using a new surgi-

cal tape. There is less superficial irritation, induration and abscess formation by this non-suture method. A low incidence of skin sensitivity was noted. Important to the physician and patient is the ease of the application and removal of the tape.

Booth 38. Identification of the Ameba Histolytica in Tissues—William A. Jarrett, M.D., and Robert Dreher, R. T., Department of Pathology, St. Peter's General Hospital, New Brunswick; and Veterans Administration Hospital, Bath, N. Y.

The purpose of this exhibit is to demonstrate reactions of the ameba organisms to various stains and counter-stains, designed to demonstrate all histologic features as accurately as possible. The exhibit shows the reactions of the ameba histolytica to various staining technic. Conclusions reached: Stains employing a silver technic are probably the most reliable.

Booth 39. External Ocular Infection—A Controlled Study with Triclobisonium Chloride—Richard U. Stern, M.D., Walter T. Rados, M.D., John Insabella, M.D., Herbert L. Moskowitz, M.D., and Humbert M. Gambacorta, M.D., United Hospitals of Newark—Eye and Ear Infirmary Unit, Newark

One hundred twenty unselected clinic patients with external ocular infection (conjunctivitis, corneal ulcer) were treated with triclobisonium chloride, a new anti-microbial drug. Causative pathogens were cultured and identified; the predominant organism was found to be staphylococcus. The clinical efficacy of the drug was evaluated. Laboratory animal studies were also undertaken to extend the evaluation. Results are graphically portrayed.

Booth 40. Progress in the Management of Essential Hypertension—Garfield G. Duncan, M.D., Robert J. Gill, M.D., William J. Jenson, M.D., Brooks W. Gilmore, M.D., and Richard B. Freeman, M.D., The Pennsylvania Hospital, Philadelphia, Pa.

The exhibit outlines methods of medical treatment for the four grades of hypertension and contains a graphic illustration of the pharmacologic sites of action of the various drugs employed. There are several illustrations of cases responding to treatment. In addition to drug therapy, other points in the management of the hypertensive patient are mentioned.

Booth 41. The Feet in Rheumatoid Arthritis—John J. Calabro, M.D., Carlo Nosenzo, M.D., and Felix Traugott, Seton Hall College of Medicine, and Jersey City Medical Center, Jersey City

The feet in rheumatoid arthritis may assume characteristic configurations, often so striking that a diagnosis of the disease can be had by merely being cognizant of these changes. This exhibit portrays colored wax moulage models of feet showing typical rheumatoid changes with special emphasis on cock-up toes, metatarsal head depression, metatarsal spread, thickened Achilles' tendons, hallux valgus and corns, calluses and bunions over bony prominences. X-rays corresponding to wax models will demonstrate radiologic aspects—demonstrating thickened Achilles' tendons and osseous lesions in the sub-Achilles, subplantar and metatarsal head areas.

Booth 42. Common Sense Management of Upper Respiratory Tract Disease in Childhood—Walter L. Mitchell, M.D., and John C. Dower, M.D., United Hospitals of Newark—Babies Hospital Unit, Newark

The dominant theme of the exhibit is a positive plea for the use of antibiotics on specific indication only. Certainly disease of the upper respiratory tract is the commonest therapeutic situation in which the child confronts the pediatrician. In our opinion, the diagnostic possibilities resolve into three main groups. A. Disease that can be clinically recognized and requires specific treatment—the classic example is streptococcal infection. B. Disease that can be clinically recognized and usually requires no antibiotic treatment—classic examples are measles, herpangina, gingivostomatitis. C. Disease that is usually not recognizable on clinical examination—the vast majority of these infections fall in the No Man's Land of Undifferentiated Upper Respiratory Infection, viral illness requiring no antibiotic therapy. These concepts are supported by the use of graphic material illustrating the pathology referred to above.

Booth 43. Care and Treatment of Extremities in Diabetic Patients—The Study of Controlled Release of Dermatologic Agents—J. C. Pomeranze, M.D., and J. L. Rosenfeld, M.D., New York Medical College and Lincoln Hospital, New York, N. Y.

The purpose of this study is to describe our experiences in treating over 100 diabetic patients with acute and chronic pyogenic infections. Various preventive and therapeutic measures are described. Emphasis is placed on the three pre-requisites for management of these cases: 1. to dry the affected areas without irritation from topical agents; 2. restore the acid/base balance; and 3. inhibit any infection present. Some new and old topical forms of therapy are described and appraised.

Educational Exhibits

Gallery, Lounge floor

Exhibit Hours: 1:00 p.m. - 5:00 p.m., Sunday, May 15, 1960
9:00 a.m. - 5:00 p.m., Monday and Tuesday, May 16 and 17, 1960
9:00 a.m. - 1:00 p.m., Wednesday, May 18, 1960

Booth 1. Some Aspects of Mental Health—New Jersey State Department of Institutions and Agencies, Trenton

A still exhibit with text, charts and pictures dealing with a phase of the State Department mental health program.

Booth 2. Ready for Work—New Jersey Rehabilitation Commission, Trenton

Pictorial study of clients receiving services in the rehabilitation process.

Booth 3. Rehabilitation of the Cancer Patient—American Cancer Society, New Jersey Division, Inc., Newark

The exhibit depicts the rehabilitation of patients who have had radical mastectomy, laryngectomy, or colostomy. Panels illustrate: 1. Special *problems* imposed by each site; 2. *Specifics* which require individualization of each patient's care; 3 *Principles* which are applicable to all cases; and 4. *Objectives* for maximal restoration of the patient to family and society.

Booth 4. The Temporary Disability Insurance Program—State Division of Employment Security, Trenton

The exhibit shows how the doctor's patients can benefit from the State's temporary disability insurance program, an income-protection scheme which is part of the employment security program along with unemployment compensation. Patients who are too sick to work, and whose illness is not work-related, can draw benefits up to $35 per week for 26 weeks. The program applies to all workers who are covered by unemployment compensation.

Booth 5. Intradermal Tuberculin Testing—New Jersey State Department of Health, Division of Preventable Diseases, Trenton

Demonstration of selected technics used in intradermal tuberculin testing.

Booth 6. Strike Back at Stroke—New Jersey State Department of Health, Division of Chronic Illness Control, Trenton

Illustrative presentation of technics used in restorative care of stroke patients.

Booth 7. Association of American Physicians and Surgeons, Inc.—Joseph A. Lepree, M.D., Elizabeth

Literature and posters explaining the functions of the organization.

Booth 8. Quackery in Arthritis—The Arthritis and Rheumatism Foundation, New Jersey Chapter; and The New Jersey Rheumatism Association, Newark

The Arthritis and Rheumatism Foundation, in conjunction with government agencies and the medical profession, has launched a nation-wide drive on quackery in arthritis. The Foundation has turned over to the Post Office Department, the Food and Drug Administration, and the Federal Trade Commission a six point program to control the practice of these predators. This program is based on a recent nation-wide survey conducted by The Arthritis and Rheumatism Foundation. The exhibit will show misrepresented items, photos of medicines, devices, etc., and "quack cures"—"$250,000,000 Swindle." The incidence of such "cures" for arthritis is as wide-spread as the crippling disease itself. Each year 11 million sufferers are cheated out of one-quarter billion dollars by quack predators.

Booth 9. Know Your State Society—The Medical Society of New Jersey, Trenton

Organization Chart of The Medical Society of New Jersey detailing the channels of contact within the Society, with other medical organizations, and with lay health agencies. Descriptive literature will be available for the information of interested members.

Technical Exhibits

Lounge floor

Exhibit Hours: 1:00 p.m. - 5:00 p.m., Sunday, May 15, 1960
9:00 a.m. - 5:00 p.m., Monday and Tuesday, May 16 and 17, 1960
9:00 a.m. - 1:00 p.m., Wednesday, May 18, 1960

Abbott Laboratories **Booth 26**

Members and guests of The Medical Society of New Jersey will be cordially welcomed at Abbott Laboratories' exhibit of leading specialties and new products. Our representatives will be available at the exhibit to give you information on the products and to answer any questions you may have.

Ames Company, Inc. **Booth 65**

Featured will be Dechotyl Trablets®, our new therapeutic for oral administration, combining two widely-used, well-tolerated bile acids plus an efficient fecal softener. Each yellow trapezoid shape Trablet® contains Decholin® (dehydrocholic acid, Ames), 200 mg.; desoxycholic acid, 50 mg.; and dioctyl sodium sulfosuccinate, 50 mg. Combistix®, our new "dip-and-read" Reagent Strips which are a colorimetric combination test for urinary protein, glucose and pH, will also be shown. One dip gives three results in ten seconds.

Ayerst Laboratories, Division of American Home Products Corporation **Booth 24**

A most cordial invitation is extended to all physicians to visit the Ayerst Laboratories booth where we will be featuring Premarin®, providing extra relief to the menopausal patient, Mysoline®, for control of epilepsy, Murel®, our antispasmodic agent, and our new product, Timovan®. Our representatives will be on hand to discuss with you these products and any information you might desire on our other products.

Baby Service, Inc. **Booth 59**

New Jersey's largest diaper service will be on hand for the tenth straight year with the latest scientific advances in diaper service and the famous Baby Service roses for the ladies. We extend a cordial invitation to all physicians, their families and guests to visit our booth.

The Baker Laboratories, Inc. **Booth 57**

Baker's Modified Milk and Varamel®, two successful products for infant feeding, will be displayed. Baker representatives will be glad to discuss the benefits of Baker Milk products which provide all the normal dietary requirements plus a reserve for stress situations.

Benton Laboratories, Division of Air-Shields, Inc. **Booth 44**

Featured will be: Pregular®—a 100 per cent accurate oral Pregnancy Test and menstrual regulator. Hypocal®—a *New* anti-obesity tablet. Terminatal®—the most comprehensive prenatal formula—contains 58 mg. of *elemental* iron plus a fecal softener to counteract the constipation of pregnancy. Almadon®—a *New* antacid—more rapid—more sustained elevation of pH plus modified antispasmodic action.

E. & W. Blanksteen Agency, Inc. **Booth 3**

Information and literature is available at this booth regarding The Medical Society of New Jersey plans of accident and health and life insurance.

The Borden Company **Booth A**

Most important new item at the Borden Pharmaceutical Division's booth is Liquid Bremil® which adds all the convenience of a liquid to the significant advantages already established by Bremil® Powdered. Borden's full line of formula products is on display including Mull-Soy®, the original hypoallergenic formula. Other new additions are Dermabase® and Junitar®, the nonstaining tar bath, and Marcelle® Hypoallergenic Cosmetics, pure beauty aids for delicate skins.

Burroughs Wellcome & Co. (U.S.A.) Inc. **Booth 50**

The extensive research facilities of 'B. W. & Co.,' both here and in other countries, are directed to the development of improved therapeutic agents and technics. Through such research 'B. W. & Co.' has made notable advances related to leukemia, malaria, diabetes, and diseases of the autonomic nervous system; and to antibiotic, muscle-relaxant, antihistaminic, and antinauseant drugs. An informed staff at our booth will welcome the opportunity to discuss our products and latest developments with you.

Cameron Surgical Instruments Company **Booth 63**

Displayed will be the first really successful biopsy-taking gastroscope. In addition, a brand new gastro-esophagoscope for examination only. See the "cold" cutting and coagulating electro-surgical

units in all sizes. Cameron surgical units, like Cameron diagnostic instruments, are the standard of excellence—the ones used by the most prominent doctors in the world. See the original Lempert headlight—safety model—for operating rooms with the safety current controls.

Ciba Pharmaceutical Products, Inc. **Booth 28**

Esidrix® is hydrochlorothiazide, an improved analog of chlorothiazide. Milligram-for-milligram, it is the most effective oral diuretic-antihypertensive known. Therapeutically, Esidrix® is 10 to 15 times more potent than chlorothiazide. Weight losses up to 56 pounds have been reported. In many cases Esidrix® caused copious diuresis in patients unresponsive to other oral and/or parenteral diuretics. Side effects are usually mild, infrequent and readily controlled.

The Coca-Cola Company **Booth 47**

Ice-cold Coca-Cola® served through the courtesy and cooperation of the Coca-Cola Bottling Company, Atlantic City, and The Coca-Cola Company.

Cosmevo Surgical and Orthopedic Corp. **Booth 20**

Cosmevo Surgical and Orthopedic Corp. (formerly Cosmevo Surgical Supply Co.) of Hackensack will this year display the folowing Ritter equipment: (1) Universal motor-driven examining and treatment table which enables the physician to treat more patients more thoroughly with less effort in less time; (2) BasalMeteR—a simpler, easier diagnostic tool for metabolism testing; (3) Bovie electro-surgical units (with explosion-proof footswitch) for all minor and major electrosurgery including prostatic resection, hemorrhage control, limitation of metastasis, maintenance of sterility, minimization of surgical shock and convenience in reaching inaccessible places. As always, Cosmevo will exhibit and describe its own exclusive line of patented and improved surgical and orthopedic appliances for early training and rehabilitation. Free descriptive catalogs are available.

Desitin Chemical Company **Booth 32**

Desitin® Ointment, for treatment of burns, ulcers, diaper rash, abrasion, etc.; Desitin® Powder, relieves chafing, sunburn, diaper rash, etc.; Desitin® Suppositories and Rectal Ointment, relieve pain and itching in uncomplicated hemorrhoids, fissures; Desitin® Baby Lotion, protective, antiseptic; Desitin® Acne Cream, a non-staining, flesh-tinted "Medicream" for the treatment of acne vulgaris; Desitin® Cosmetic and Nursery Soap, supermild; Desitin® Suppositories with Hydrocortisone, prompt response to inflammatory conditions in proctitis, severe pruritus, edema.

Doho Chemical Corporation **Booth 61**

Auralgan®—otitis media and removal of cerumen.

Otosmosan®—fungicidal and bactericidal in the suppurative and aural dermatomycotic ears.

Rhinalgan®—nasal decongestant free from systemic or circulatory effect.

Larylgan®—throat spray and gargle for infectious and non-infectious sore throat involvements.

Rectalgan®—for relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing.

Dermoplast®—an aerosol spray for surface pain, burns, and abrasions; obstetric and gynecologic use.

Eaton Laboratories **Booth 51**

Altafur® (brand of furaltadone), the first nitrofuran effective orally in systemic bacterial infections. High clinical efficacy in pneumonias, bronchiolitis, bronchitis, tonsillitis, and otitis media; also in soft tissue infections, cellulitis, and abscess, surgical wound infections, and infected lacerations.

Thomas A. Edison Industries, McGraw-Edison Company **Booth 42**

Edison Voicewriter—"Dictation Center U.S.A."—will show a complete line of business recording equipment designed to speed handling of medical paper work. Highlights: Edison Voicewriter M-E models . . . full-featured dictating instruments for individual use by doctors in the office and at home. Edison Escort . . . battery-operated, portable dictating instrument. Edison Envoy . . . economy-priced, magnetic tape dictating-transcribing machine. Midgetape . . . 3-pound battery-operated, portable tape recorder. Televoice . . . phone network dictating systems for accurate, complete medical records in the hospital or clinic.

Faulhaber & Heard, Inc. **Booth 4**

Information can be obtained on professional liability protection upon inquiry at our booth. Protection is also available for professional assistants, such as registered or graduate nurses, and x-ray or laboratory technicians.

Geigy Pharmaceuticals, Division of Geigy Chemical Corp. **Booth 60**

Members and guests of the Society are cordially invited to visit the Geigy technical display. Our original contributions to modern therapy of cardiovascular, rheumatic, psychiatric, and metabolic disorders will be presented by representatives in attendance.

Gerber Products Company **Booth 68**

NEW! Gerber Modilac® . . . A complete formula for infants. Gently processed to conserve nutritional values, it has true milk color and flavor. Modilac® *is* milk adapted to the infant's physiologic requirements by the addition of a selected carbohydrate, replacement of butterfat with corn oil and supplementation with needed vitamins. Ask for complete information.

Great Books of the Western World **Booth 45**

A new advancement in liberal education, spanning 3,000 years of Western Thought, from Homer

and the Bible to the 20th century featuring the master key to the Great Books—The Syntopicon. The revolutionary Syntopicon, a totally new basic reference work, accomplishing in the field of idea what the dictionary does for words and the encyclopedia in the field of facts.

Health Insurance Council **Booth C**

The Health Insurance Council serves, on behalf of the nation's insurance companies, as a central source of information and counsel to physicians, hospitals, and others in the health care field on all aspects of health insurance. The Council seeks to promote cooperation and understanding between those who provide health care and those who help finance its cost . . . to the end that the insurance business may provide the most effective and satisfactory health insurance protection possible.

Holland-Rantos Company, Inc. **Booth 25**

The H-R exhibit will feature: Specific antimycotic, non-messy Hyva® Gentian Violet Vaginal Tablets . . . Also trichomonicidal, fungicidal and bactericidal Nylmerate® Jelly and Antiseptic Solution Concentrate for vaginal trichomoniasis and mixed infections . . . Hollandex® Silicone Ointment with Natural Vitamins A & D—medication for neuro- and contact dermatitis, decubitus ulcers, diaper rash, skin dryness, chafing, etc.; . . . Special Koromex® (A) for use when "jelly-alone" is indicated for conception control; also contouring Koro-Flex® Diaphragms (facilitate correct placement), along with standard Koromex® Jelly, Cream, Diaphragms and Sets.

Johnson & Johnson **Booth 72**

Displayed will be the latest improvements in surgical dressings, as developed by the Johnson & Johnson Research Laboratories. Several recent outstanding additions to the Baby Products line will be shown. Other products, designed for your office, hospital, or patient use, will be displayed. You will find well-informed representatives pleased to discuss these products or provide information on any other items made available by the world's largest manufacturer of surgical dressings and baby products.

Kalak Water Company, Inc. **Booth 56**

Montages relating Kalak, America's leading name among sparkling alkaline waters for nearly half a century, to the role of mineral waters in aiding well-being throughout history. Literature describing Kalak's many uses as an antacid, diuretic, non-laxative adjunct toward maintaining electrolyte balance and supplementing many types of therapy.

Kessler Associate, Inc. **Booth 49**

A comprehensive prosthetic presentation representing advanced technics, products of latest research and development to be presented and demonstrated. Complete concepts of modern materials and application to newly developed prosthesis are displayed and explained by certified prosthetists who will be in attendance. Questions regarding prosthesis in general will be welcomed.

Knoll Pharmaceutical Company **Booth 66**

Vita-Metrazol® Elixir and Tablets are indicated for hastening postoperative recovery and convalescence as well as fatigue and senility. Dilaudid® Cough Syrup is available "for coughs that must be controlled." This preparation combines the antitussive Dilaudid® with the expectorant glyceryl guaiacolate. Information concerning Dilaudid® Cough Syrup, Vita-Metrazol®, Nico-Met, as well as Quadrinal® Tablets, Quadrinal® Suspension, and the new antiparkinsonism agent, Akineton, is available for your review.

Lamond Products, Inc. **Booth 17**

Dermatologic products featured: Bur-Cort®—superior hydrocortisone therapy in an exclusive emulsion base. Bur-Zin®—Burow's Emulsion for eczematous eruptions and diaper rash. Dermasorcin® and Dermasul—resorcin and sulphur, flesh-tinted, for acne and seborrhea. Dermastringe® astringent, keratolytic containing salicylic acid, resorcin, acetone, alcohol and benzalkonium chloride. Bentical®—a flesh-tinted mild, soothing antipruritic lotion (a shake lotion). Sunprotectol®—superior sunscreen lotion; hypoallergenic, aids in avoiding erythema and sunburn.

Lederle Laboratories Division, American Cyanamid Company **Booth 13**

You are cordially invited to visit the Lederle booth where our medical representatives will be in attendance to provide the latest information and literature available on our line. Featured will be Declomycin® demethylchlortetracycline, the most recent contribution to broad-spectrum antibiotic therapy, Aristocort® Triamcinolone, the highly effective, well tolerated corticosteroid, and the nutritional supplements, Stresscaps® and Incremin® with iron.

Eli Lilly and Company **Booth 34**

You are cordially invited to visit the Lilly exhibit. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

Maltbie Laboratories Division, Wallace & Tiernan, Inc. **Booth 58**

Maltbie Laboratories announces an entirely new chemical entity, Dornwal®, for treatment of anxiety and tension without causing drowsiness. Dornwal® effectively interrupts tension headache, relieves acute emotional upsets, is well suited to ambulatory patients, and is virtually devoid of hypnotic or sedative activity. Also featured are: Caldecort®, antifungal, antibacterial, anti-inflammatory dermatologic ointment; Desenex®, most widely prescribed for athlete's foot; Nesacaine®, a

safe, potent and rapid-acting local anesthetic; and Cholans®, for the treatment of hepato-biliary dysfunction.

The S. E. Massengill Co., Inc. **Booth 23**

Best wishes from Massengill to the members of The Medical Society of New Jersey for a most successful and informative meeting! Should you so desire, capable Massengill representatives would be pleased to discuss with you any Massengill products in which you are interested. Products being featured are Adrenosem® (the unique systemic hemostat); Homagenets® (the only solid homogenized vitamins); Obedrin® (superior weight-reducing aid); The Salcort® Family (offering a complete range in arthritic therapy); Saferon® (the peptonized iron); Massengill Powder (the douche preparation of choice). If you wish them, literature and samples will be available.

McNeil Laboratories, Inc. **Booth 16**

Members of The Medical Society of New Jersey are cordially invited to visit our booth—No. 16, Mr. A. A. Hower in charge. Products to be featured are: Butiserpine®, Butisol Sodium®, Grifulvin®, Parafon®, and Twiston®.

Mead Johnson & Company **Booth 22**

The Mead Johnson exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

Medco Products Co. **Booth 9**

An entire new approach to medicine's oldest therapies, the Kol-Therm®. Instantaneous moist or dry pack, cold or hot at pre-set temperatures constantly controlled at temperature desired. Contrast therapy at 3 controlled settings. Also exhibited—the Medco-Sonlator®, a new concept in therapy for myofascial syndromes providing diagnostic and therapeutic potentials. Locates and treats trigger points through simultaneous application of sound and stimulation. Also available—the well known Medcolator®.

Medical-Surgical Plan of New Jersey **Booth 15**

The exhibit of the Medical-Surgical Plan of New Jersey (Blue Shield) will highlight the extended benefits now available through riders to group subscribers of the Plan. New in 1959, at extra cost, are benefits for pathology, physical therapy, and out-of-hospital x-ray services, radioactive therapy, extra medical days, and for surgery of a cutting or cauterizing nature outside of the hospital. Also illustrated will be the mounting payments made to Blue Shield participating physicians through the years for services rendered to the nearly 2 million subscribers. Blue Shield cordially invites physicians and their wives to visit its display and talk with Plan representatives, who will be glad to answer any questions pertaining to the Plan.

Menlo Park Laboratories, Inc. **Booth 53**

Vaga-Spray®, the modern aerosol vaginal cleanser, is a quaternary germicidal surfactant (cetyl trimethyl-ammonium bromide) in a soothing, spreading and penetrating water soluble lanolin base, buffered to pH 5.0. Vaga-Spray® is safer, cleaner, more convenient, and much more effective than vaginal douches. Vaga-Spray® may be used in bed. Takes 2 seconds. Economical—about 10 cents per use. No fuss. No mess. Your patients will appreciate RX Vaga-Spray®.

The Mennen Company **Booth 7**

The Mennen Company will exhibit Baby Magic®, America's favorite baby lotion; famous Baby Oil and Baby Powder for anti-diaper rash protection; and, in addition, Mennen Quinsana®, the fast-acting foot powder that kills athlete's foot germs painlessly.

Merck Sharp & Dohme, Division of Merck & Co. **Booth 37**

A new adrenocortical steroid is featured at the Merck Sharp & Dohme booth. Decadron® dexamethasone possesses all the basic actions and effects of other glucocorticoids but in different degree. Its anti-inflammatory activity is more potent on a weight basis than any other known glucocorticoid. Electrolyte imbalance is not ordinarily a therapeutic problem. HydroDIURIL®, a new, orally effective, non-mercurial diuretic-antihypertensive agent is also of interest. This compound is the most potent diuretic agent presently available, equaling or exceeding even the most potent parenteral organomercurials in diuretic activity. Technically trained personnel will be present to discuss these and other subjects of clinical interest.

The Wm. S. Merrell Company **Booth 31**

You are cordially invited to visit The Wm. S. Merrell Company booth where products of particular interest to the doctor will be displayed. Cooperative and highly trained Merrell representatives will be on hand to answer your questions. These men will be most happy if you plan to spend some time with them. We look forward to visiting with you during this fine convention.

Milex of New York **Booth 62**

Gynecological products will be featured—Trimo-San® for trichomonas, monilia, and mixed leukorrheas will be introduced. Amino-Cerv Cervical Gel® will be demonstrated as the treatment of choice for cervicitis and post-cervical surgery. Samples of *A Doctor Discusses the Menopause*, and *A Doctor's Marital Guide for Patients* available on request.

Mooreland Associates **Booth 69**

A market research and management consulting firm, specializing in the medical profession and al-

lied industries, is conducting a survey on various aspects of medical practice and drug therapy. Your participation would be greatly appreciated.

The Mutual Benefit Life Insurance Company **Booth 41**

Specialists manning the Mutual Benefit booth are familiar with financial planning problems peculiar to the physician. Helpful suggestions on inexpensive disability compensation and overall estate planning are getting the main emphasis this year. A number of worthwhile booklets and reprints are available: *Estate Planning for Physicians; Retirement Dollars for Professional People; What Every Physician Should Know About Tax-Free Disability Dollars; Can You Retire, Doctor;* plus a specially prepared financial planning portfolio for the doctor.

The National Drug Comapny **Booth 33**

Tepanil®, Orenzyme® and AVC Suppositories® are being featured at our exhibit. Tepanil®—for weight control. A completely new compound that curbs the appetite without CNS stimulation. Tepanil® is safe, well tolerated, and suitable for evening use on patients of *all* ages. Orenzyme®—the *first oral* anti-inflammatory enzyme tablet on the market. Orenzyme® is *swallowed*—just like an aspirin tablet. Orenzyme® is indicated for treatment of any acute inflammatory process when swelling slows recovery. AVC Suppositories®—a completely new vaginal suppository providing all the proved effectiveness of AVC Improved Cream®. AVC Suppositories® are highly effective in controlling all the common types of vaginal infections—trichomonal, bacterial and fungal. Please stop by.

Nordson Pharmaceutical Laboratories, Inc. **Booth 6**

Ergomar®, a new form of specially processed ergotamine tartrate specifically for sublingual administration in the treatment of recurrent and throbbing type vascular and migraine headache. Bypassing the gastric and hepatic enzymatic barriers, Ergomar® insures more rapid relief and avoids gastric upset. Also featured—Levonor®, the non-stimulating appetite suppressant. Levonor's® smooth action permits its use even during the late evening hours without disturbing sleep. Latest reprints are available on Ferronord® Liquid and tablets, a chelate hematinic providing rapid hemoglobin response without side effects.

Organon, Incorporated **Booth 52**

Physicians are cordially invited to visit the Organon booth for information on useful therapeutic specialties. Included among these will be: Durabolin®—a new, safe, potent, long-acting biologic stimulant indicated in all conditions where a tissue-building action is desired. Durabolin® provides its potent tissue-building effects without the drawbacks and dangers characteristic of tissue-building steroids. No masculinization occurs in recommended dosages. No progestational effects can occur. Organon representatives will gladly discuss Durabolin® and other specialties with all interested physicians.

Ortho Pharmaceutical Corporation **Booth 5**

Ortho is introducing a new monilicidal vaginal cream, Sporostacin®. This emollient white cream contains the unique chemical, chlordantoin which, because of its structure, has the unusual ability to penetrate the monilial membrane. Clinically proved, Sporostacin® Cream is the treatment of choice in monilial vaginitis. Ortho is also proud to present its new blood clot dissolving agent, Actase® Fibrinolysin (Human), for use in thrombophlebitis and pulmonary embolism.

Oxy Swig, Inc. **Booth 21**

Oxy Swig, Inc. announces production of two portable oxygen units designed for physicians from criteria set by physicians. Oxy Swig®—Light, highly portable, 56-liter unit. Designed for office emergencies and house calls. Constant measured flow. Oxygen mask valves insure against rebreathing dangers. Carrying case and adaptor for quick refill. Metrox®—A 305-liter unit for use when larger supplies of oxygen are required and portability is less a factor. Equipped with carrying case, refill adaptor and Oxy Swig safety mask.

Pepsi-Cola Metropolitan Bottling Co., Inc. **Booth 14**

Pepsi-Cola Company invites members and guests to visit its booth to enjoy a refreshing Pepsi-Cola®. Pepsi-Cola® is served through the courtesy and cooperation of the Pepsi-Cola Company and its franchised bottlers in New Jersey.

Pfizer Laboratories **Booth 70**

The Pfizer Laboratories' display has been specifically arranged for your convenience and to give you the maximum in quick service and product information. To make your visit worthwhile, technically trained medical service representatives will be on hand to inform you of the latest developments in Pfizer research.

The Purdue Frederick Company **Booth 71**

Featured will be: Senokot®—constipation corrective. Concentrated total senna glycosides which activate Auerbach's plexus, initiate normal neuroperistalsis. Arthropan®—New rapidly absorbed choline salicylate, producing anti-inflammatory, analgesic, antipyretic effects in a short time without gastric irritation. Pharycidin®—the first triple action throat medication. Provides medical and systemic analgesia plus anti-bacterial action through gargling and swallowing. Cerumenex®—cerumenolytic for the quick removal of excessive cerumen. Contains Cerapon, a new surfactant, with propylene glycol and chlorbutanol.

Roche Laboratories, Division of Hoffmann-LaRoche, Inc. **Booth 2**

Roche representatives will provide the latest information and literature on our products. Featured will be Madribon® and Tigan®.

J. B. Roerig and Company **Booth 43**

Members of the medical profession will be welcomed at the J. B. Roerig and Company exhibit of leading specialties and new products. Representatives will be in attendance to answer any questions you may have. Roerig recently introduced a number of new products which representatives at the exhibit will describe and provide information on the results of clinical reports.

William H. Rorer, Inc. **Booth 1**

Featured: Maalox®, the non-constipating, pleasant tasting antacid, and the new double strength Tablet Maalox No. 2. Other product highlights are Ascriptin®, a rapid-acting professional salicylate: Fermalox®, a buffered iron preparation; Fermatin®, a dynamic tonic in a capsule; and Parepectolin®, a pleasant tasting antidiarrheal preparation for patients of all ages. Representatives will be on hand to answer questions about these and other Rorer products.

Ross Laboratories **Booth 30**

Manufacturers of Similac®, our exhibit will feature Similac® With Iron, a new prepared infant formula supplying 12 mg. of ferrous iron per quart of formula. Similac® With Iron is designed for use when iron is indicated in infancy, for maintenance of iron stores, to provide prophylaxis against iron-deficiency anemia and to support the normal diet. Some special indications for use are following placental or traumatic blood loss, for prematures and twins, for the pallid, irritable, anorectic infant with an unsatisfactory blood picture and following prolonged infection or diarrhea.

Sandoz Pharmaceuticals **Booth 35**

You are cordially invited to visit our display—Mellaril®—the first potent tranquilizer with a selective action (i.e.—no action on vomiting centers). This unique action gives specific psychic relaxation with safety at all dosage levels. Cafergot PB® —the most effective oral medication for the relief of migraine headache with gastro-intestinal disturbance accompanied by tension. Plexonal®—preferred daytime sedative-relaxant. Superior to both the barbiturates and meprobamates. Any of our representatives in attendance, will gladly answer questions about these and other Sandoz products.

W. B. Saunders Company **Booth 8**

Our representative will be on hand with the complete line of Saunders books. Among the wide variety of titles are helpful books for any sort of modern practice; books especially geared to today's medicine.

Schering Corporation **Booth 18**

Schering Corporation welcomes the members of The Medical Society of New Jersey. Featured products include Miradon®, the new oral anticoagulant with predictable control proved by 5 years' preintroductory clinical experience. Fulvicin®, the first oral antifungal antibiotic for ringworm; Delenar®, the new corticoid-relaxant-analgesic that keeps the rheumatic man in action; and Rela®, a new muscle relaxant-analgesic that eases sprains, strains, and low back pains.

G. D. Searle & Co. **Booth 40**

Our representatives will be happy to answer any questions regarding Searle Products of Research. Featured will be Mornidine®, the new synthetic recommended to prevent or stop nausea and vomiting associated with pregnancy, anesthesia, radiotherapy and gastroenteritis; Dartal®, the new tranquilizing agent which controls activities associated with anxiety states and other neuroses; Enovid®, the new synthetic steroid for treatment of various menstrual disorders; and Nilevar®, the new anabolic agent. Also featured, will be Vallestril®, the new synthetic estrogen with extremely low incidence of side reactions; Pro-Banthine® and Pro-Banthine® with Dartal®, the standards in anti-cholinergic therapy; and Dramamine® and Dramamine-D®, for the prevention and treatment of motion sickness and other nauseas.

Smith Kline & French Laboratories **Booth 38**

S.K.F. features: (1) new Ornade Spansule® capsules, the unique oral nasal decongestant that contains a special drying agent in addition to a decongestant and an antihistamine; (2) Fortespan® capsules, high potency multivitamins (therapeutic formula) in Spansule® *sustained release* capsules; and (3) Eskatrol Spansule® capsules, the tranquilizer-anorexigenic to relieve underlying psychic stress and curb appetite in psychogenic overweight.

South Jersey Surgical Supply Co. **Booth 27**

South Jersey Surgical, this year will demonstrate the "All New" Burdick Model EK-III Electrocardiograph. Also on display will be new diagnostic and surgical instruments.

E. R. Squibb & Sons **Booth 29**

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the medical profession in new products or improvements in products already marketed. At booth No. 29, we are pleased to present up-to-date information on these advances for your consideration.

William Allen Steadman & Company **Booth 11**

William Allen Steadman & Company were the originators of complete financial service to the medical profession. This company is the investment adviser and the underwriter for Steadman Investment Fund, Inc. It is also the underwriter for Professional Service, Inc. These companies were organized at the request of a group of New Jersey physicians in order to provide financial and

investment assistance from internship through retirement. Physicians and their wives are cordially invited to visit the booth.

Stiefel Laboratories, Inc. **Booth 19**

Brasivol®, newest development in the therapy of acne, will be featured at the Stiefel booth. Register for a free, full-size trade package of Brasivol®, mailed with our compliments to your home or office.

Thermo-Fax Sales, Incorporated **Booth B**

The medical profession has made great strides technologically. These have benefited the patients. More recently, practitioners have been looking for more efficient and thriftier ways of administering their offices; for a way to increase the return on an investment in training and ability. Many have found one good answer to be the Thermo-Fax Brand Copying Machine researched by Minnesota Mining and Manufacturing Company. If you are that exception, a businessman and a professional man, why don't you stop at the Thermo-Fax Sales, Inc. booth for some details?

U. S. Vitamin and Pharmaceutical Corporation **Booth 55**

DBI®—a new "full-range" oral hypoglycemic agent. DBI®, brand of phenformin (N^1-B-phenethylbiguanide HCl) is distinctly different in chemical structure and physiologic action from the oral hypoglycemic sulfonylureas. It effectively lowers blood sugar and eliminates glycosurja in mild, moderate and severe diabetes. DBI®, in combination with insulin, improves regulation of "brittle" adult and juvenile diabetes. In juvenile diabetes, DBI® often permits up to 50 per cent reduction in insulin requirement. Also effective in the insulin-resistant, and in primary and secondary tolbutamide and chlorpropamide failures. Full details available.

The Upjohn Company **Booth 64**

Professional representatives are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

Walker-Gordon Laboratory Company **Booth 46**

You are invited to taste-test Walker-Gordon Certified milks. You will find the new Certified Lo-Sodium Milk, which has been especially processed to reduce its sodium content from around 500 to less than 50 mg. per quart. Walker-Gordon Acidophilus Milk, Certified Pasteurized Milk, and Certified Skimmed Milk will also be available. The Walker-Gordon Laboratory Company's Certified Milk Farm in Plainsboro, N. J., is the world's largest farm producing Certified Milk. It includes over 2,400 acres of farm land and 2,690 cows and growing heifers. It is the home of the famous Rotolactor, the purpose of which is to make possible the production of the highest quality milk. Walker-Gordon Certified Milk is distributed in the metropolitan area of New York and Philadelphia and in the State of New Jersey by many leading milk dealers.

Wallace Laboratories, Division of Carter Products, Inc. **Booth 48**

Our representatives will be glad to discuss a new non-hormonal agent—Soma®—to relieve pain, stiffness, and spasm in muscle and point complaints. It has been highly effective in many musculoskeletal disorders, including arthritis, fibrositis, myositis, spondylitis, backache, sprains, contusions, and whiplash injuries. Soma® relieves pain and stiffness promptly. No side effects other than sleepiness have been observed.

Wampole Laboratories, Division of The Denver Chemical Mfg. Co., Inc. **Booth 12**

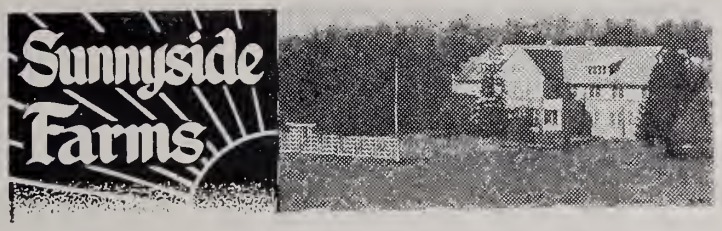
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lief of the atonic bowel. Warren-Teed representatives cordially welcome all registrants to visit their display.

Westwood Pharmaceuticals, Division of Foster-Milburn Co. **Booth 10**

Fostex® Cream, Fostex® Cake, Sebulex®, Lowila® Cake, and Lowila® Emollient—unique dermatologic products—will be featured. These products are particularly suitable for personal use by physicians and their families, who may be plagued with dandruff, acne, dry, itchy skin and sensitivities to soap. Register, so that we may send prescription units to your home.

White Laboratories, Inc. **Booth 67**

White Laboratories exhibit features Permitil®, a new anxiety agent which promises in everyday office practice, the control of a significantly wider range of the "target symptoms" of emotional stress with the smallest, safe dosage (0.25 mg. b.i.d.) of any neuroleptic agent. Permitil® alleviates symptoms of anxiety and agitation without depressant effect or impaired alertness. Permitil® has an inherently long duration of effectiveness making it a convenient morning and evening dosage schedule. Also featured is a new scientific contribution in the treatment of allergic disorders, Disomer®. Our representatives will be glad to discuss this new product with you.

Winthrop Laboratories **Booth 39**

Trancopal®, the first true "tranquilaxant"—potent muscle relaxant and effective tranquilizer. Trancopal® is used for low back pain and other musculoskeletal disorders, anxiety and tension states, dysmenorrhea, premenstrual tension, etc. It combines an unusually high rate of clinical effectiveness with low toxicity; side effects are less than 3 per cent. Available in two strengths: 100 mg. Caplets (peach) and 200 mg. Caplets (green). Average adult dose, 100 or 200 mg. three or four times daily.

ADDED ATTRACTION FOR OUR ANNUAL MEETING



CHALFONTE - HADDON HALL SWIMMING POOL

Pictured above is a new feature of the Chalfonte-Haddon Hall which, we think, will be the scene of many informal scientific discussions during our 1960 Annual Meeting.

Atlantic

Louis Rosenberg, M.D., President, Atlantic City

It has been my honor to be the 68th President of the Medical Society of Atlantic County. A great deal has been accomplished through the cooperation of the Executive Committee, the officers, and the numerous active committees. Much of this will not be evident in a factual report. A county society can and should have a prominent part in community activities, and we have accordingly tried to integrate our policies through our public relations program. These are the projects that have been actively undertaken in the past year:

1. A weekly radio broadcast, entitled *Your Doctor Speaks,* on which a moderator interviews a different physician each week on medical or allied subjects.

2. A weekly article in the Sunday newspaper, entitled *Capsules of County Medicine,* on medical or related subjects. These articles as well as the broadcasts, enjoy a wide popularity with the public.

3. An annual science award for high school seniors of Atlantic County. A $50 bond is awarded to the high school seniors with the highest averages in the sciences. It is presented at a suitable ceremony.

4. A medical student loan program has been inaugurated at a county level, and is now in operation.

5. An active Speakers' Bureau has provided speakers for civic and other lay groups. The Bureau supplies to member speakers material obtained from state and national levels. All speakers clear their topics, not only for an official record, but for avoidance of any controversial issue.

Although programs in the past have been traditionally scientific ones, it was the feeling of the Executive Committee and of many of the members of the Society, that the true function of a society should be to promote a better understanding with allied and non-medical groups. Accordingly, our December 1959 meeting was of a social nature, to which were invited the members of the judiciary, political leaders and heads of allied organizations. The speaker was a well-known professional football player. Our February 1960 meeting was a semi-social affair: a combined meeting with the members of the Bar Association, arranged for a panel discussion of the Interprofessional Code which had already been mutually adopted. The panel consisted of three physicians and three attorneys, and pertinent questions in regard to the Code were answered from the floor. This very interesting program easily fulfilled the purpose of the meeting; to promote a better relationship between lawyer and doctor.

Our March 1960 meeting was "Problems of Modern Day Medical Education." The speaker was Dr. Jonathan Rhoads. The April program was "The Doctor and His Investments." It is probable that with us as with other societies, future programs will be entirely non-scientific. It certainly appears to be a desirable and inevitable trend.

An intensive study of the problem of eastern equine encephalitis was made during the past year. This was a serious local problem, and something new not only to us, but to the entire state. As a result of the study made by our Public Health Committee (and specifically by its chairman, Dr. Max Gross) a formal resolution was adopted by this Society. Recommendations in this resolution were made to the county and state departments concerned. Serious consideration of these recommendations might well be a definite factor in preventing a recurrence of this tragic disease.

A large number of emergency medical calls are made in a seashore resort such as this during the summer months. Because of this, our Emergency Medical Service must not only be smoothly functioning but also well publicized. To facilitate this program, a special emergency telephone number is planned for the near future, and this will operate in the same manner as police and fire emergency calls.

At the request of The Medical Society of New Jersey, a poll was taken on the compulsory inclusion of all physicians in the Old Age and Survivors Insurance Act. Of 119 members polled, 69 were in favor of, and 50 opposed to the plan.

The Society adopted a resolution expressing its opposition to a proposed Blue Cross

rider which would provide coverage of outpatient diagnostic services, including radiology and pathology, in hospitals.

The Society was urged to support a proposed Special Blue Shield Subscription Contract to provide special health insurance for people over 65 with low family income. Many members were opposed to certain provisions in the contract, and it was apparent that considerable clarification would be needed before the required support could be obtained. The importance of the over-all purpose of the program was stressed.

Several of our members are active in community political affairs, others in civic groups. This was actively encouraged because the need for adequate representation is apparent.

During the past year, six members were elected to the Society: Two associate members, one from associate to regular membership, two transfer members from other societies, and one courtesy member. The Society regretfully reports the death of three of its members.

A new Editor of our *Bulletin*, Dr. Herbert Axilrod, was appointed this year. A new secretary, Dr. John Holland, was elected. Both have capably and adequately filled their difficult positions. It is only through the cooperation of the Executive Committee and the officers of the Society, with the added support of all committees and of each individual member, that this term of office has enjoyed some measure of success.

Bergen

Donald B. Hull, M.D., President, Ridgewood

As the population of Bergen County continues to "explode" and as our membership roster continues to lengthen, the Society has diligently tried to expand its spheres of activity. New special committees have been added as follows: Committee on Medical Examiners Office, Committee on Hospital Liaison and Subcommittee on Cardiac.

MEMBERS

Forty new applications were inspected and applicants interviewed by our Membership Committee. All but one were approved; 17 became regular members; 22 were elected to associate membership.

A new routine has been established to comply with the new Bylaws of The Medical Society of New Jersey. Under this procedure, applications will be first screened by the Membership Committee and then approved by the Executive Committee for presentation to the Credentials Committee of The Medical Society of New Jersey. Formal election is withheld until approval from all three has been secured.

MEETINGS

Ten meetings were held during the past year. The speakers and subjects were:

April 14, 1959—"Is Blue Shield Fair To The Doctor?"—Panel Discussion

May 12, 1959—"Psychiatric Aspects of Surgical Practice"—Dr. Bernard C. Meyer, New York

September 15, 1959—"Practical Problems In The Care of Older Patients"—Dr. George W. Warner, New York

October 13, 1959—"Recent Advances in Endocrinology"—Dr. Joseph W. Jailer, New York

November 10, 1959—"Proposed Recognized Public Health Activities and Minimum Standards of Performance for Local Health Departments"—Discussion—Dr. Jesse B. Aronson, Trenton

December 8, 1959—"Hypnosis In The General Practice of Medicine"—Dr. Milton H. Erickson, Phoenix, Arizona

January 12, 1960—First Annual Smoker

February 9, 1960—"Unusual X-Rays of The Chest"—Panel Discussion—Dr. Emanuel Klosk, Newark, N. J.; Dr. Coleman B. Rabin, New York

March 8, 1960—"The Management Of Occlusive Arterial Disease"—Dr. Henry Haimovici, New York

The Passaic *Herald News* once more co-sponsored two public medical forums, one on

"That Virus 'Bug' "; the other on "Can You Help the Alcoholic?"

The Speakers' Bureau has had another busy year; 44 talks have been made before lay groups, and 4 Adult Education Series presentations were conducted by local schools in which 35 separate presentations were delivered. Other talks are being presently organized for next fall.

JUDICIAL COMMITTEE

The Judicial Committee has had 10 meetings and considered 27 complaints. Acting in accordance with the recommendation from the American Medical Association, a well-known resident has been added to the committee as a lay member. This pilot program has not yet been advertised to the public.

Burlington

ROBERT E. HALDEMAN, M.D., President, Mount Holly

This year began with an organizational breakfast, at which time the agenda for the year was reviewed and several innovations instituted. All committee chairmen accepted their appointments and worked harmoniously and efficiently with their own committees and the Society as well. Our regular meetings are held at the Millside Farms Dairy Bar, Route 130, Riverside. Based on a poll of our members it was decided to change our meeting hour from 9:00 p.m. to 8:00 p.m. This change has been well accepted. In our Society of 110 members we have averaged 50 per cent attendance at all meetings, which is excellent in a predominantly rural county like ours.

The members of the Executive Committee have cooperated exceedingly well, giving many hours and much thought to the problems brought to them. It is through this cooperative spirit that many hours have been saved from discussions on the floor at our meetings. It is gratifying that the Society usually accepts their recommendations. Incidentally, we terminate our meetings at a favorable hour and with digestive systems able to enjoy our buffet supper that follows!

Dr. Harold L. Colburn, Jr., and his Program Committee, have done an outstanding job. At the beginning of our year, this Committee proposed that as many Society members as possible join with them at dinner with the speaker for the evening. This excellent practice has made our speakers feel welcome and given them a feeling that they were acquainted with some of their audience and not total strangers. This thought has been expressed by the speakers themselves.

The Committee presented the following program for our 1959-60 meetings:

September 10, 1959: "The Diagnosis and Treatment of Superficial Fungous Infections" by Herbert A. Luscombe, M.D., Head of the Department of Dermatology, Jefferson Medical College.

October 8, 1959: "Newer Physical Methods of Therapy for Malignant Disease" by Robert Robbins, M.D., Director of Radiologic Therapy, Temple University Medical College.

November 12, 1959: "Rehabilitation in Medicine" by Carl A. Maxwell, M.D., Consultant in Orthopedic Surgery at Kessler Institute and a member of State Medical Rehabilitation Commission.

December 10, 1959: "Newer Concepts in Management of Diseases of the Eye" by Irving Leopold, M.D., Chairman of the Department of Ophthalmology, Graduate School of the University of Pennsylvania.

January 14, 1960: "Obesity" by Perry A. MacNeal, M.D., Associate Professor, Clinical Medicine, University of Pennsylvania.

February 11, 1960: Annual joint dinner meeting with the Burlington County Bar Association. Speaker, Louis B. LeDuc, Esq., "Advocacy—or—Why Lawyers Take Unpopular Cases." These joint dinner meetings were instituted in 1940 and, except for the war years, have been an annual affair and have proved to be excellent public relations.

March 10, 1960: "Resistant Bacterial Infections" by Harrison F. Flippin, M.D., Professor of Clinical Microbiology, Graduate School of the University of Pennsylvania.

April 14, 1960: Annual meeting as guests of Deborah Hospital, Browns Mills, New Jersey. "The Place of Planigraphic Examination in Thoracic Diagnosis" by George Sommer, Jr., M.D.; J. M. Fruchter, M.D.; and Nathan Ralph, M.D., of the Staff of Deborah Hospital. The staff and personnel of the hospital have been cordial and cooperative, the scientific portion of the program has always been instructive, and we have enjoyed our visit to Deborah Hospital at Browns Mills.

May 12, 1960: Our annual "Ladies' Night" at

Medford Lakes Log Cabin Lodge, a dinner-and-dance affair with good entertainment. Among the featured dancers will be our own Bill and Helen Betsch.

Dr. J. Howard Hornberger and his committee on Constitution and Bylaws have accomplished the revisions necessary to adjust our Constitution and Bylaws to the provisions of the Constitution of The Medical Society of New Jersey. These changes have been approved by our Society.

The Board of Censors, under Dr. Ralph H. VanMeter, has done exceptionally well with the new membership application forms recently instituted by the State Society. This committee has had several other problems, and its decisions have been concise and definitive.

Public Health Committee, subcommittee on School Health, has completed a survey of all the school districts in our county and have recommended that all children receive poliomyelitis vaccine prior to admission to school. With nine exceptions, all of the school districts have made such immunization mandatory for entrance. This Society hopes that the State Legislature will change the wording of the new law from "may" to "shall"—it seems to be the only way to manage the "die-hards."

A special Interprofessional Relations Committee, headed by Dr. E. Vernon Davis, was appointed to meet with a similar committee of the Burlington County Bar Association. These sessions resulted in the adoption by the Burlington County Medical Society of the "National Interprofessional Code for Physicians and Attorneys" as jointly promulgated by the American Medical Association and the American Bar Association. In addition the two professions agreed on three procedural rules regarding release of information, pre-trial conferences, and arrangements to attend court. It is certainly a step toward better understanding between the physicians and the lawyers.

After an informative report by Dr. Luis E. Viteri, Chairman of our Nurse Scholarship Committee, it was recommended that this scholarship be discontinued in its present form after it has fulfilled its obligation to the present recipients.

We were again the guests of the Burlington County Pharmacists' Association at a dinner. This well-attended meeting was an excellent public relations function. Some of the pharmacists' problems were discussed and in many instances were similar to our own.

The Woman's Auxiliary to the Burlington County Medical Society deserves commendation this year for its efforts to establish and maintain the "Visting Homemakers' Service of Burlington County." The Auxiliary is now recruiting women to be trained as visiting homemakers, and service is expected to begin in May. Our enthusiastic Auxiliary deserve help both morally and financially. We are making every effort to give them both. Mrs. John C. Voss, President of the Homemakers' Service, and Mrs. Arthur C. Dietrick, President of the Woman's Auxiliary, have both done an exceptional job in the initiation of this community service.

The newly developed Levittown, New Jersey, involves an entire township and will, by the end of 1960, house 60,000 people. This has given some cause for concern. The problem of hospitalization is serious. A construction project known as the "Physicians and Surgeons Hospital of Levittown" is in the process of formation. A location has been secured and they are currently engaged in financing it. They contemplate a 50-bed hospital with plans for an additional 50 beds as soon as possible. The promoters of this hospital have requested informative help from the Burlington County Medical Society and have agreed that all staff appointments will be members of our local Society. Of course there has been an influx of physicians from all schools and types of practice, and the Society has had several problems to deal with. We have made much effort to afford them as much security as possible within our ability and have outlined for these doctors appropriate measures that are within proper ethical procedures.

I have saved my conclusion for comment on the work done by the Editor-in-Chief of our *News Letter*, Dr. William E. Bray, and his assistant, our dynamic Secretary, Dr. Winfield Betts. They have done an exceptional job for the past several years in the publication of our own *News Letter* which is circulated to our membership. This publication contains editorials on timely topics, public relations articles, announcements of graduate courses and seminars, minutes of the Society meetings and Executive Committee meetings, news of our Burlington County Hospital and Zurbrugg Memorial Hospital, and reports of the activities of the Woman's Auxiliary, as well as other items of interest to the medical profession. This bulletin is in the hands of the members prior to each meeting, so that the physicians are prepared for the agenda. This has saved countless hours of discussion at meetings.

In addition, Dr. Bray and Dr. Betts are

compiling a "Physicians' Information Directory" which will include listings of the Society members, officers, committees; para-medical associations; procedures on admissions to hospitals and to County and State institutions; hospitals and hospital staffs; clinics of all types; nursing homes; visiting nurses associations; emergency squad information; school health laws and other public health and safety rules and regulations; fire and police organizations; laws for adoption and a listing of licensed agencies; County recreational facilities; and many other matters of interest which are difficult to find. This directory will be issued in loose-leaf binder form, with additions and supplements being made available at intervals, so that it may be kept current. These two physicians deserve a great deal of credit for the thought and many hours they have put in on this project.

Cumberland

Benjamin Berkowitz, M.D., President, Bridgeton

The year opened with a picnic graciously tendered by the Owens-Illinois Glass Company at their cabin and picnic grounds at Palatine Lake. The Glass Company were hosts to the doctors and the Woman's Auxiliary, serving broiled lobsters, steaks and all the trimmings. It was a fine beginning for the Society's year of activities.

At every meeting there was a scientific session with outstanding speakers. Eight new members and two associate members were admitted into the Society making our total membership approximately 100. Our constitution and bylaws were brought up to date. The County Diabetic Detection Drive Committee was quite active; 691 tests were done. Of these, 682 were negative and 9 positive. These nine were not aware that they had glycosuria.

One of the most active committees in our Society was the Maternal and Infant Welfare Committee with its Prenatal Subcommittee. They have held meetings with the Prenatal Committees of the three major hospital staffs in our county in order to study infant mortality more fully to seek some common trend in etiology.

On December 28, 1959, the Executive Committee of our Society, together with its Committee on Public Health took official recognition of a proposed private commercial venture to dispose of Philadelphia refuse on a New Jersey shore. A resolution was drafted which pointed out the dangers of such a project to the health and welfare of the people in this area, together with the dangers to a Government-owned Wild Life Preserve and Sanctuary and to nearby oyster beds. The resolution was sent to the Board of Chosen Freeholders, petitioning them to use every means at their disposal to block this project. Protests from physicians and other interested groups was so vehement that I believe the proposed venture has been dropped.

All in all, the year has been an active one; pleasant, interesting, and rewarding.

Gloucester

Dorothy M. Rogers, M.D., President, Woodbury

Regular monthly meetings, September to May inclusive, on the third Thursday of each month (except for October) were held at the Woodbury Country Club. The program follows:

September: Dr. H. P. Shipps, Chief Attending Gynecologist at Cooper Hospital: "Gynecology in General Practice."

October: At Tavistock Country Club, with wives and guests, our State President, Dr. Bowers and Mrs. Bowers and others. Our speaker was Dr. Kenneth Jackman from the Hill School, Pottstown, Pa., with a very graphic and entertaining demonstration, audience participating, on the "Principles of Rocketry"—both instructive and highly amusing.

November: *Subject*—"Nutrition and Coronary Disease;" *speaker*—John F. Mueller, M.D., of the faculty of the University of Cincinnati and principal investigator in a research program on nutritional studies in fat metabolism.

December: *Speaker*: Dr. Paul Nemir; *topic*: "Vascular Surgery."

January: Gloucester County pharmacists were our guests. Richard J. Coyne, M.D., discussed "Pharmaceutical Research."

February: With the possibility of difficult travel at this time of year, we took this opportunity of hearing from our own members. *Speaker*; Chester L. Samuelson, M.D.; *topic*: "Significance of Transverse Process of Seventh Cervical Vertebra." *Speaker*: Richard P. Gotchel, M.D.; *topic*: "Single Dose Caudal Anesthesia in Obstetrics" (movie). *Speaker*: Cornelius J. Regan, M.D.; *topic*: "Local Anesthesia—Indications and Complications."

March: The local members of the Gloucester County Bar Association were our guests. *Speaker*: A. M. Ornsteen, M.D.; *topic*: "Disorders of Motility" (sound-color moving picture film).

April: Dr. L. K. Ferguson spoke on: "Surgery of the Ambulatory Patient."

May 19: Will be Ladies' Night, with A. E. Rakoff, M.D., endocrinologist, as speaker.

Our membership varies, averaging 70. Our attendance averages about 22 members. We are about to adopt a revised constitution. Our debts are paid. Our members have fulfilled their financial obligations to the Society. We are aiming to care adequately for all, especially the indigent and aged, to earn the respect accorded to the followers of our art.

Middlesex

John A. Smith, M.D., President, South River

The Middlesex County Medical Society will have completed another successful year this June. Among its significant accomplishments have been:

1. The incorporation of the Society into a non-profit organization.
2. Revision of its constitution and bylaws and subsequent publication in loose-leaf book form.
3. Institution of a "sign in" attendance record, published in our *Bulletin* each month.
4. Defense of a court action instituted against the Middlesex County Medical Society. This was done with the cooperation of The Medical Society of New Jersey.
5. A joint meeting with the Middlesex County Bar Association, which was attended by seven Judges of our Courts.
6. Creation of an active liaison committee between physicians and lawyers for the better cooperation between the two professions.
7. A joint meeting with the Middlesex County Pharmaceutical Association.
8. Varied and instructive scientific programs.
9. Publication in the *Bulletin* of the various departmental conferences being presented in the hospitals of our county each month.
10. Actively stimulating our members to oppose the Forand Bill and similar legislation.

Monmouth

Lester A. Barnett, M.D., President, Long Branch

This year in our County Society's history has been marked by an unprecedented interest in the economics of medical practice, stimulated by national events and the efforts of our Program Chairman, Dr. Harold Gabel. Record attendances at meetings have heard discussions on medical malpractice, the Forand Bill, Social Security legislation, and changing trends in hospital and medical insurance. These programs have been well balanced with scientific and social programs, the latter with the assistance of the Woman's Auxiliary who, as always, have been strong partners in communication and planning.

The many committees have functioned well, as heretofore, with special attention directed to our Public Relations Committee who have edited articles written by the membership for weekly publication in the press as a Monmouth County Medical Society column. One of our radio stations broadcasts interval announcements of our Emergency Medical Service, which is now in its twelfth year of function. Our Judicial Committee acts as our Grievance Committee and in turn solves many of our public relations and malpractice problems. The Liaison Committee with Blue Cross has been expanded to include the study of all types of hospital and health insurance.

New committees have been formed to meet current problems. They are Indoctrination Committee, Emergency Medical Service Committee, Legislation Committee and the Committee on Investigation of Radioactivity. Their purposes and needs are self-explanatory. The Medico-Legal Code was adopted by the Bar Association and our Society.

Many of our members are represented at the Annual Meeting in Atlantic City in both legislative and scientific presentation. Our membership has grown to over 340 and continues to expand with the population growth of Monmouth County. Thus the problems and duties of administration increase, but the unselfish cooperation of the Officers, Executive Committee, Committee Chairmen and the membership at large have made the task fruitful and enjoyable. And weaving us together into one smoothly functioning organization is our indispensable Executive Secretary, Mr. Vincent J. Gorman.

Morris

Augustus L. Baker, Jr., M.D., President, Dover

The Morris County Medical Society followed its usual plan of combining business meeting and scientific programs in October, November, February, March and April. Dinner meetings were held in January and June. At the Annual Meeting in June, the new officers were elected.

At the October session, two of our members reviewed (by means of questionnaire) the professional liability insurance status of the membership. These doctors made recommendations under two headings:

(a) To the Morris County Medical Society:

1. That individual members consider the advisability of obtaining personal guidance at the local level in connection with their insurance coverage. The best person to do this is a competent agent in the physician's own community.
2. That individual physicians make a specific effort to acquaint themselves with the problems involved in liability coverage not only for their own protection but to improve professional cooperation, especially at the rapidily proliferating organizational level.

(b) To The Medical Society of New Jersey:

1. Abolishing its policy of withholding from local agents the names of new members in the Society.
2. Encourage participation by local agents in the selling of individual policies under the State contract.

3. Establish a liaison with the central representatives of the state organization of insurance agents and brokers in order to develop a higher level of familiarity with the problems in the field.
4. Develop a personal inventory form for professional liabilities which can be used by the individual physician to enable him to detect weakness in his coverage to facilitate the development of adequate coverage.
5. To prepare a comparative analysis of the professional liability policies registered in Trenton for insurance to physicians within the state.

In November, the scientific program was by Dr. Robert Sullivan of New York City, who spoke on cancer chemotherapy. Dr. Sullivan presented recent advances in cancer research along these lines and had a very interested audience.

In February, we heard Dr. Harry Aaronow of New York City, who spoke on humeral factors in cardiovascular disease.

The March and April meetings presented the endocrinologic background of menstruation, and recent advances in our knowledge of virus diseases, respectively.

During the year, the Morris County Medical Society backed the "Dollars for Dooley" drive and have progressed well in collection of money for this worthy cause.

The Society prepared a flyer, distributed by the "Welcome Wagon" to new families in the area, helping acquaint them with the physicians in the area and recommending how to obtain a doctor in case of emergency. Also, a letter was sent to the business organizations and manufacturing plants in the area to help them get medical coverage for use and in case of an emergency.

Fourteen new members were added to the Morris County Medical Society this year. Dr. Joseph Donovan was elected to life membership in the Society. Dr. Jennie Beaver will be honored as a Golden Merit award winner at the Annual Meeting of The Medical Society of New Jersey in May.

Passaic

Julian Cohen, M.D., President, Paterson

The past year has been a stimulating and productive one for the Passaic County Medical Society. My fellow officers and the chairmen of the committees have been active and cooperative in maintaining all of the vital functions of the Society. The *Bulletin*, published monthly, has served to keep our members informed of both local and national medical events of importance to the practicing physician. The Executive Offices located in our own headquarters building, have been functioning smoothly and efficiently, and our financial structure is sound and strong.

The "crash" campaign for poliomyelitis vaccination was a tremendous success, and one that we can be justly proud of. Many of our members participated actively by giving the injections at Boards of Health, hospitals, clinics, and schools throughout the county. The services of the physicians were offered without fee. Thousands of children and adults were given protection against poliomyelitis.

Our monthly scientific programs presented two innovations. The first was a joint meeting with the Passaic County Bar Association, where a panel of physicians and lawyers discussed the Inter-Professional Code recently adopted by the American Bar and Medical Associations. The second deviation from the usual routine of having one speaker give a scientific paper was the use of a panel of three visiting medical authorities moderated by one of our own members. Two such programs were arranged. The attendance was large on both occasions, and the meetings were unquestionably the high spots of the year.

The Passaic County Medical Society offered recommendations to the city officials of Paterson regarding the appointment of a new Health Officer, and to the Board of Chosen Freeholders who were considering the choice of a County Physician. Our suggestions were accepted by both official bodies, and, we hope, that in this way, we have made a contribution to the maintenance of a sound public health program both in Paterson and in Passaic County.

Our Building Committee has been reactiv-

ated and has held regular monthly meetings. Programs to improve the facilities at our Headquarters are being discussed, and some worthwhile advances are in the offing. A new emergency call panel has been set up and sent to all of the telephone-answering services, the hospitals, the police departments, and the Red Cross. The annual public health forums sponsored jointly by the Medical Society and a local newspaper have been continued at their usual high level of efficiency. The fine rapport which exists between the Society and our Woman's Auxiliary has been helpful in many instances to the mutual benefit of both organizations.

The Welfare Council and the Board of Censors deserve a special vote of thanks. They performed their time-consuming, and sometimes, tedious duties faithfully throughout the year. I am extremely grateful to Mr. Randall Norris, our Public Relations Counsel, to Mrs. Katherine Cingale, our Executive Secretary, and to her assistant, Mrs. Catherine Quinn. The Committee Chairmen and the active members of their committees have all done a yeomanlike job. Many thanks to all of you.

Salem

George A. Nitshe, Jr., M.D., President, Monroeville

Thus far in the 1959-1960 season, the Salem County Medical Society has adopted the National Inter-Professional Code for Physicians and Attorneys and appointed a liaison committee to the Salem County Bar Association; it has endorsed the program of the proposed Salem County Guidance Center; and it was one of the first two counties in the state to enlist over 51 per cent of its membership in the new Blue Shield program which offers reduced rates to those over 65. Six new diabetics were found in the 1959 Diabetes Detection Drive. Dr. John T. Dooley was elected to membership in the Society, and Dr. Frank L. Perry was transferred to the Atlantic County Society.

Programs for the year have included a description of the Blue Cross rider for out-patient diagnostic services, dietary management in coronary artery disease, facial pain and headache, competition in the drug industry, dermatologic advances, and cellular physiology in the heart.

Union

Nathan S. Deutsch, M.D., President, Plainfield

Our Society celebrated two anniversaries this year. Our annual meeting was the ninety-first session of the organization and our Executive Offices were established just twenty-one years ago with Dr. Katherine Falconer-Slater as the Executive Secretary. In 1942, Dr. Falconer-Slater resigned and was succeeded by Miss Rogers who had been her assistant since 1939.

One of our leading members, Dr. L. Greeley Brown was honored recently by the New Jersey Urban League and by the B'nai B'rith of Elizabeth for his work in the community. Dr. Brown has seldom missed a meeting of the Society and has, for many years, served as a Delegate to The Medical Society of New Jersey.

The Public Relations Committee carries on its increased responsibilities with satisfaction to all who work with it. The committee cooperated with the Elizabeth Board of Health to obtain physicians to give Salk vaccine injections to the special group of public school children not covered through the regular pro-

grams. Several representatives of the "Welcome Wagons" are distributing material on referrals and emergency services.

The Press Dinner which is an annual event is beneficial in our public relations. The members of the press are most cooperative in helping us with our problems, particularly in presenting our side of any story that may be sent to them with adverse criticism of the medical profession.

This year we held a joint dinner meeting with the hospital administrators, our Hospital Credentials Committee and the officers of the Society to discuss the many mutual problems affecting the physicians and the hospitals. It was enthusiastically felt that such a meeting has been needed for a long time and one should be held periodically for further discussions and recommendations.

The Blood Bank Committee has climaxed an intensive study of several years of blood banks in the county by establishing the Union County Blood Bank System, Inc., with national approval by the National Institutes of Health. A central blood bank system was established over a year ago but with the N.I.H. approval it will now be possible to assist our patients both in the county and out of the county through our new credit system.

Our Civil Defense Committee has been unusually active. Recently, this committee set up the sixth mobile hospital unit in the county. The Medical Assistants Society members have volunteered to participate in the mobile hospital unit program and will provide nursing and clerical assistance. The group has also taken the First Aid Course given by the American Red Cross. Dr. Karel, the chairman of the Civil Defense Committee, is most enthusiastic about the work of the UCMAS members and feels that they will render an important service in his program. Dr. Karel is also a member of the Civil Defense Committee of The Medical Society of New Jersey.

The Legislative Committee has been active this year with the Forand Bill its most pressing project. Miss Rogers, while in Washington recently, paid a visit to Congresswoman Florence P. Dwyer who spent a great part of the day discussing matters of importance to our profession. It was a most informative visit which included a personally guided visit to the House of Representatives where Mrs. Dwyer spoke briefly from the floor on a matter of interest. The Chairman of our Legislative Committee also paid a visit to Congresswoman Dwyer to discuss legislation and our Society will be kept well informed.

One of the programs given this year was a panel presented by prominent lawyers in our county who were so enthusiastic that the Union County Bar Association gave a program several weeks later to which they invited two of our members to speak on medico-legal matters. A Medico-Legal Liaison Committee has been appointed by the Union County Bar Association and our Society. This committee studied the Inter-Professional Code and as a result of the recommendation of this committee both societies adopted the code. The committee will continue to study and make recommendations concerning mutual problems affecting the doctors and lawyers. The Program Committee has done excellent work in the selection of the programs throughout the year.

The Society had the privilege of having Dr. Bowers, president of The Medical Society of New Jersey and Mr. Nevin, the Executive Officer, as its guests on January 13, 1960. The Society had a dinner to which the officers and chairmen of the most active committees attended in order that our State officials might hear at first hand some of the important work being done. To prove that our past presidents do not "retire," ten of the chairmen at the dinner are past presidents. Each chairman gave a brief synopsis of his committee's work.

The associate membership still continues with an average of 35 members and each year a fine group of physicians become part of our Society, and active in its deliberations. The Indoctrination Committee holds the two meetings a year to assist new members to become an integral part of our organization so that they may understand the importance of being a good citizen as well as a good member of the Society. The best public relations are those directly between patient and doctor, particularly in the first contact with his patients. We feel that our associate membership is one of the most important constructive changes that has been inaugurated by our Society.

The Emergency Medical Service Committee works closely with the Indoctrination, Public Relations and Judicial Committees and each year we find the service improving. We have recently received permission from the Elizabeth Board of Education to distribute cards giving information as to the proper use of our emergency service and encouraging the public to have a family physician. It is part of our program for the above listed committees to educate the public to have a family doctor. However, more and more people each year call our Executive Office for assistance

when they become residents in the area. The committee meets periodically with the managers of our telephone exchanges to discuss mutual problems and make recommendations to better our service to the physicians and their patients.

The Child Welfare Committee made a comprehensive survey of child health problems in the county. This report was most commendable and was forwarded to the chairman of the State Committee, White House Conference on Children and Youth, by request.

Our county has gone on record by resolution to expand the Board of Trustees of The Medical Society of New Jersey. It is felt that by this means continued touch may be maintained between the grass roots of the component county societies and the top echelon during the interim between the meetings of the House of Delegates.

We feel that for better communications between state society officers that the annual dinner of the Board of Trustees should include incoming component county presidents so that the anticipated programs for the year may be presented and discussed for possible implementation.

The Woman's Auxiliary has been most active under the leadership of Mrs. Phyllis Romano. The Auxiliary has been most cooperative with the County Society and its nurse scholarships are still one of its leading projects.

The Outing Committee provided a most enjoyable day with golf and fishing and a delightful buffet supper at the end of the day.

The Medical Assistants Society in the county is fundamentally in the program of the American Association of Medical Assistants. We are proud that the initial group in the state was organized in Union County and we feel that further state recognition would be most beneficial. Good medical assistants are invaluable to physicians and they perform important functions that benefit our organization.

The administrative work of the Society is carried out by our executive staff in a competent manner as always. Mrs. Fitzgerald has proved a most efficient addition to our staff and is doing good public relations work not only in the office but in her contacts outside of the office. Miss Rogers continues to attend many meetings in interest of the society. Through her memberships in health, welfare, education and specialty groups she gives information and cooperation wherever and whenever she can. Referral work is still a major part of office routine and each year more and more of our members call for assistance on many and varied problems. If the staff cannot supply the information requested, they can direct the question or problem to the proper committee or organization.

I would like to thank all of the members for their support, the committees for their activities, Miss Rogers for her assistance and Mrs. Fitzgerald.

Warren

James H. Spillane, M.D., Reporter, Phillipsburg

At our first meeting of 1959, on February 17, we voted against Social Security for physicians, but endorsed mandatory poliomyelitis inoculation for school children. At this meeting there was much discussion as to whether our membership should be represented on the hospital Board of Directors. This was further reviewed at a special meeting on March 31 at which time definite plans were drawn to seek representation. At the April 21 session, this subject was again brought up and it was decided to postpone action for the present time. At this meeting we were fortunate to have as our guest speaker, J. Wallace Hurff, M.D.

At our June meeting we received a complete report of the State Society's meeting at Atlantic City from our President. Business of the day also included a discussion of the National Interprofessional Code between attorneys and physicians, of which our group was in favor.

Mr. James Zotti of the Medical-Surgical Plan of New Jersey was our guest speaker at our October meeting, a subject which was stimulating to everyone. Also at this meeting a letter from Mr. Hansbury announcing the Cancer Society Seminar in Newark on December 22 was read.

Our Social Meeting and Christmas Party on December 19 was a great success.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

APRIL, 1960 • VOL. XXXII, NO. 4

THE COURSE OF SARCOIDOSIS AND ITS MODIFICATION BY TREATMENT

In a series of 200 patients with sarcoidosis spontaneous remission was common. Antituberculous therapy was not effective but early improvement was noted with corticosteroids.

It is not surprising to find more than one therapeutic regime advocated for a disease so unpredictable as sarcoidosis. This report analyzes the effects of treating sarcoidosis with antituberculous or corticosteroid drugs, and the results are contrasted with those observed without treatment.

PATIENTS STUDIED AND METHODS

The material consists of 200 patients in whom clinical and/or radiological features were supported by histological evidence of sarcoid tissue. Patients with histological evidence of local sarcoid tissue reactions, without generalized disease, were excluded. A course of treatment lasted for at least three months.

Antituberculous therapy consisted of a combination of two or three established drugs—streptomycin, isoniazid, or p-aminosalicylic acid—in conventional dosage.

Corticosteroid therapy was given by mouth and/or locally. Cortisone was used initially in daily oral doses of 100 mg., but this was supplanted by 20 mg. daily of prednisolone and more recently by triamcinolone in daily oral doses of 16 mg.

Some patients received antituberculous, and later corticosteroid, therapy; the response to each course is assessed and charted separately. Thus, the same patient may figure in more than one column. When skin and eye lesions coexist, the patient is included under the clinical condition for which a particular treatment was indicated. The response to treatment was assessed by clinical, radiological, and histological means. The subjective clinical response was corroborated, whenever possible, by objective signs. Chest radiographs were done at three-month intervals as long as changes were taking place and were continued at six-month intervals when static.

The course of bilateral hilar lymphadenopathy associated with erythema nodosum is benign, and spontaneous resolution is usual within a year. The chest radiographic findings in patients with erythema nodosum have been excluded in order to prevent distortion.

Radiographs of hands and feet showing bone changes were repeated after courses of treatment and again within one year. The histological response was evaluated by serial biopsies from skin, the sites of positive Kveim tests, the liver and from nasal mucosa. The follow-up period has never been less than two years.

CLINICAL RESPONSE

The clinical response is shown in Table 1.

RADIOLOGICAL RESPONSE

Most patients (88%) with bilateral adenopathy eventually showed clear chest radiographs without treatment. Of the patients who presented at later stages with hilar adenotherapy and pulmonary mottling the percentage of those clearing was less. With antituberculous chemotherapy and corticosteroid therapy the percentage of those clearing was still less. When cutaneous or ocular involvement accompanied pulmonary sarcoidosis, spontaneous resolution of the radiological changes was less likely.

D. Geraint James, M.D., and A. D. Thomson, M.D., *The Lancet, May 23, 1959.*

Table 1—Clinical Response in Untreated and Treated Patients with Sarcoidosis

Clinical Condition	Untreated		Antituberculous Chemotherapy		Corticosteroid Therapy		
	Number	Improved	Number	Improved	Number	Improved	Relapsed
Subacute iridocyclitis	3	3	1	—	8	8	—
Chronic iridocyclitis	5	—	4	—	14	5	14
Conjunctivitis	8	8	—	—	—	—	—
Keratoconjunctivitis	4	1	—	—	3	3	—
Enlarged lacrimal glands	1	1	1	—	3	3	—
Conjunctival follicles	1	1	1	—	2	2	—
Periphlebitis retinae	—	—	—	—	1	—	—
Lupus pernio	4	—	3	—	5	5	5
Plaques	4	—	2	—	6	6	6
Maculopapular eruption	5	5	—	—	3	3	—
Erythema nodosum	60	60	1	1	1	1	—
Salivary-gland involvement	4	3	1	—	3	3	—
Bell's palsy	4	4	—	—	—	—	—
Meningitis	—	—	1	—	1	1	—
Splenomegaly	15	8	4	—	10	10	5
Peripheral lymphadenopathy	47	37	5	2	18	18	7

DISCUSSION

The minimum criteria used in this series for the diagnosis of sarcoidosis are twofold. There should be evidence of generalized involvement and also histological proof of sarcoid tissue. Clinical or radiological manifestations alone are too wide a diagnostic finding, and isolated histological evidence could be construted as a local sarcoid-tissue reaction.

The over-all pattern of sarcoidosis is that of a benign self-limiting condition. The results of treatment depend on the type of disease. In this context an arbitrary division may be made into subacute and chronic forms.

Table 2—A Comparision of Subacute and Chronic Sarcoidosis

	Subacute or transient	Chronic or persistent
Clinical condition	Subacute iridocyclitis Conjunctivitis Maculopapular eruptions Erythema nodosum Salivary-gland involvement Bell's palsy Lymphadenopathy	Chronic iridocyclitis Keratoconjunctivitis Lupus pernio Plaques
Radiology	Bilateral hilar lymphadeopathy	Pulmonary mottling Bone cysts
Histology	Epithelioid cells Giant cells	Epithelioid, giant cells, and fibrous tissue
Spontaneous remission	Frequent	Rare
Recurrence after corticosteroid therapy	Rare	Frequent

Since it is impossible to foretell spontaneous resolution, steroids are indicated for subacute iridocyclitis to avoid devastating chronic sequelae.

In contrast, skin lesions do not progress from a subacute to a chronic stage. From the onset, they are either transient or persistent.

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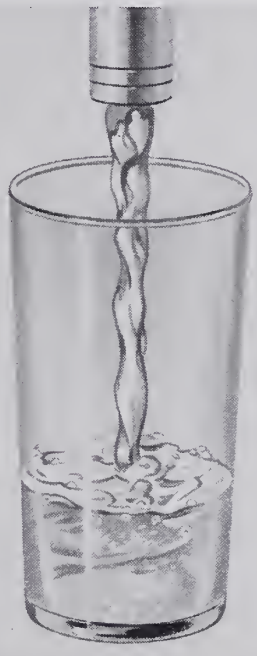
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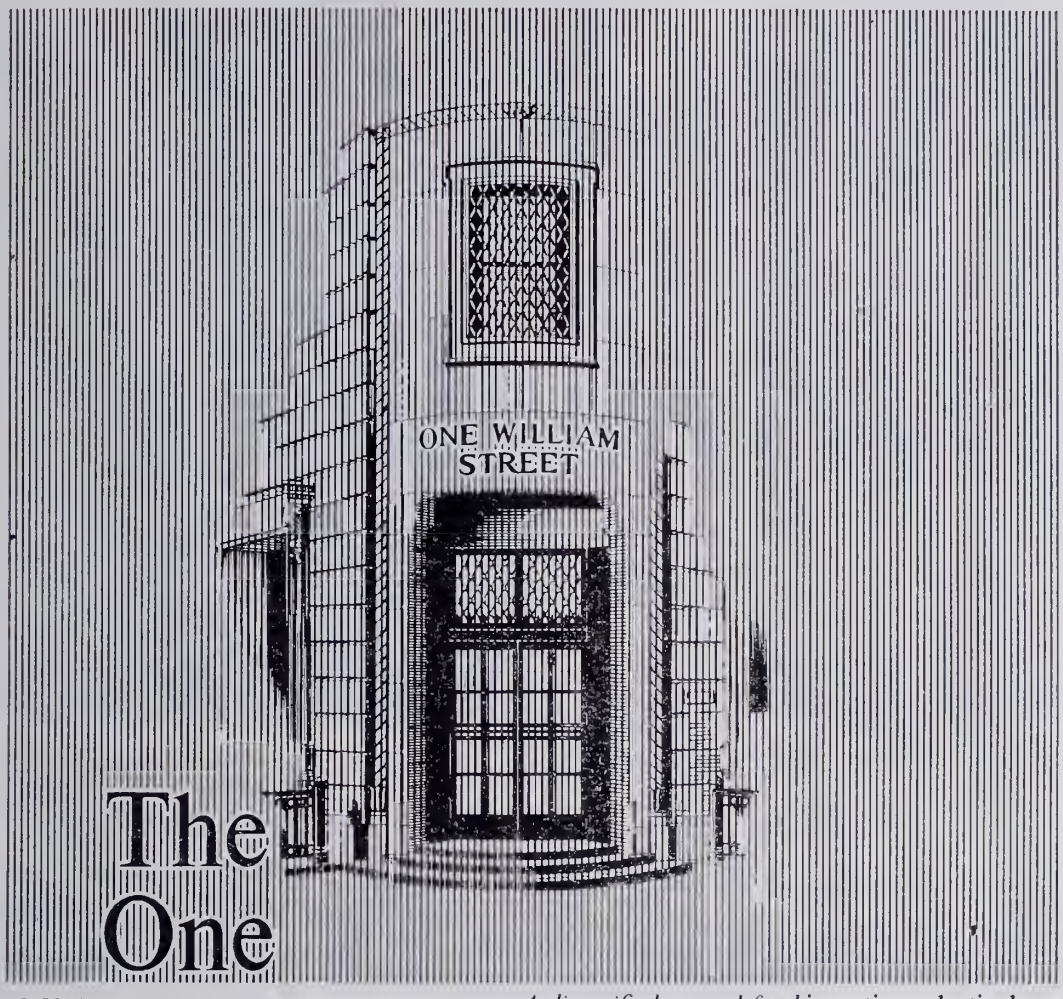
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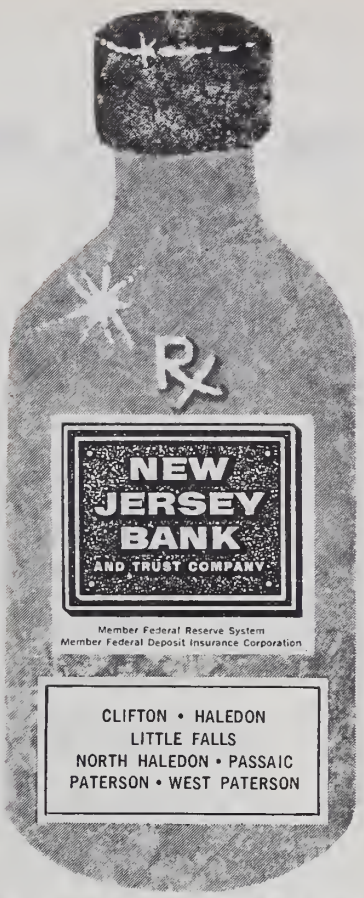
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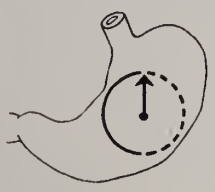
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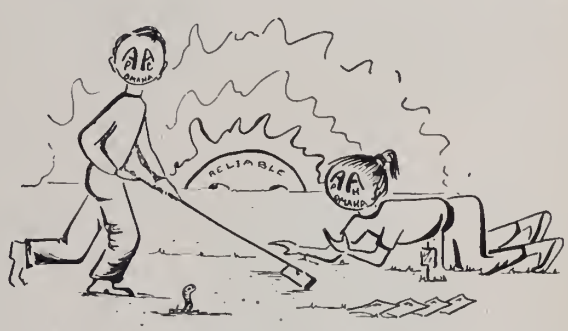
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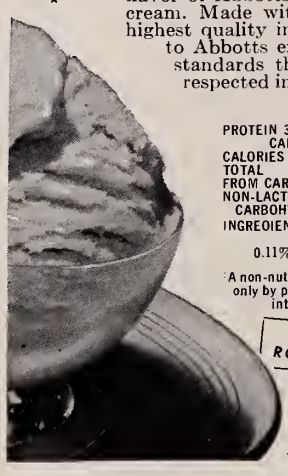
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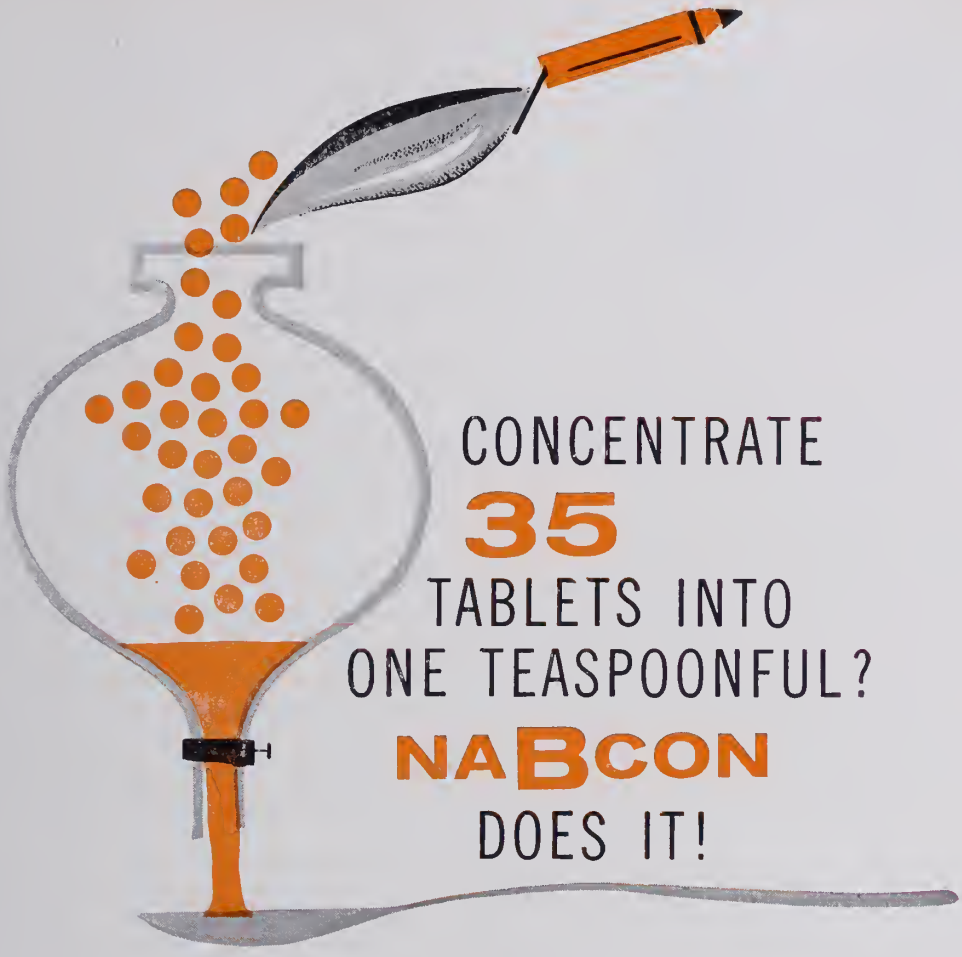
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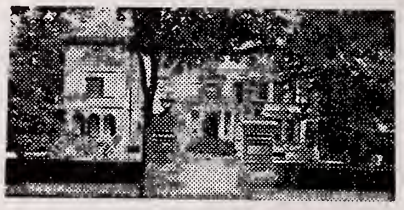
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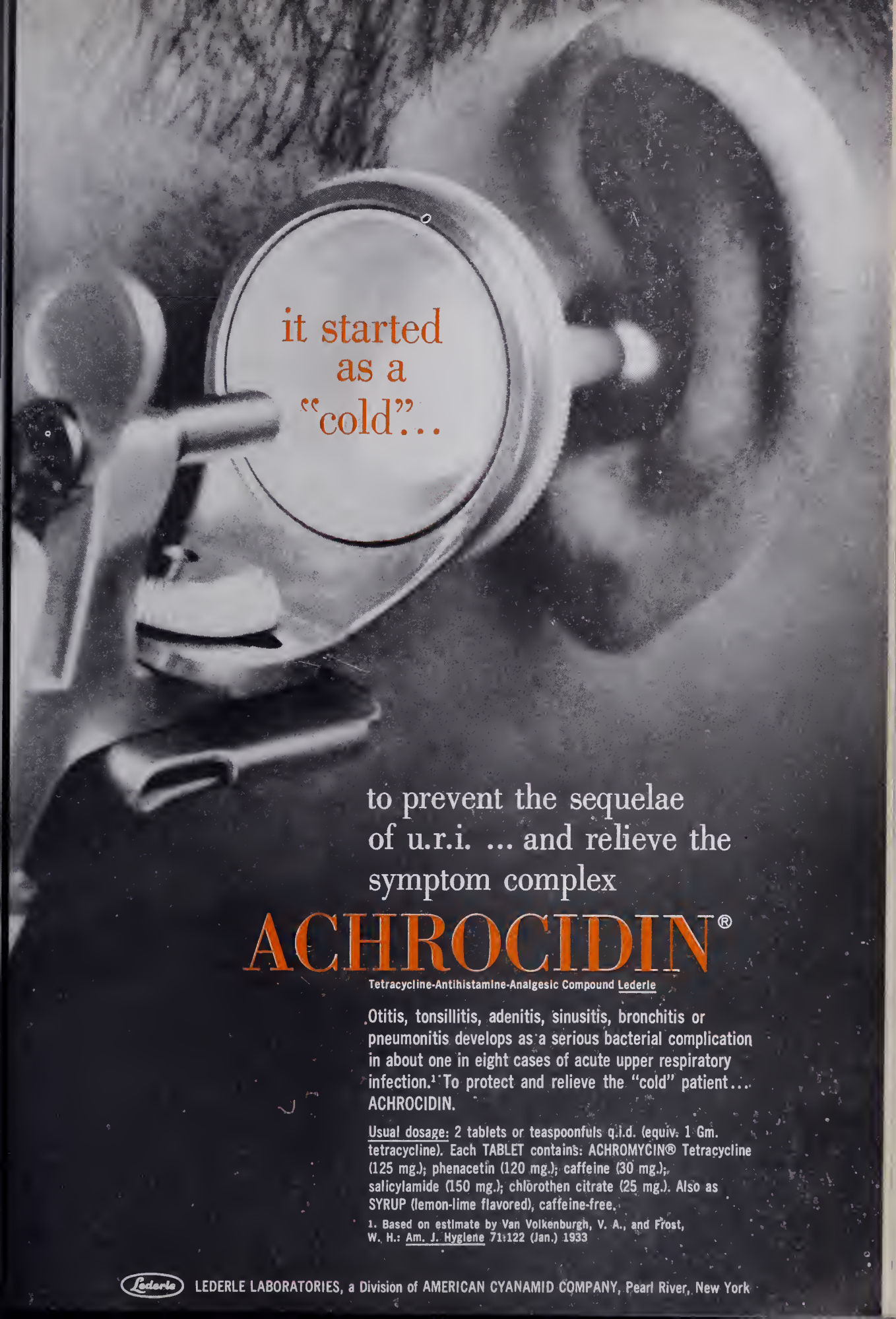
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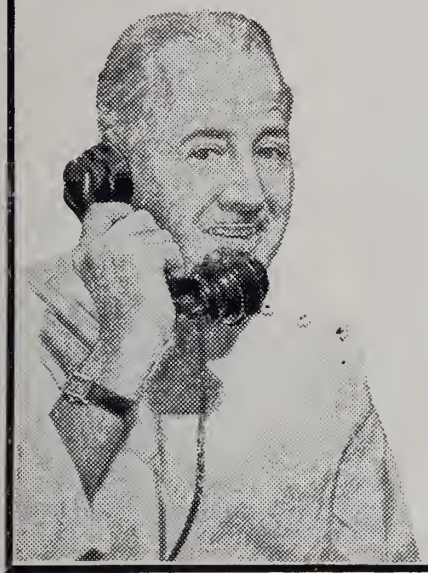
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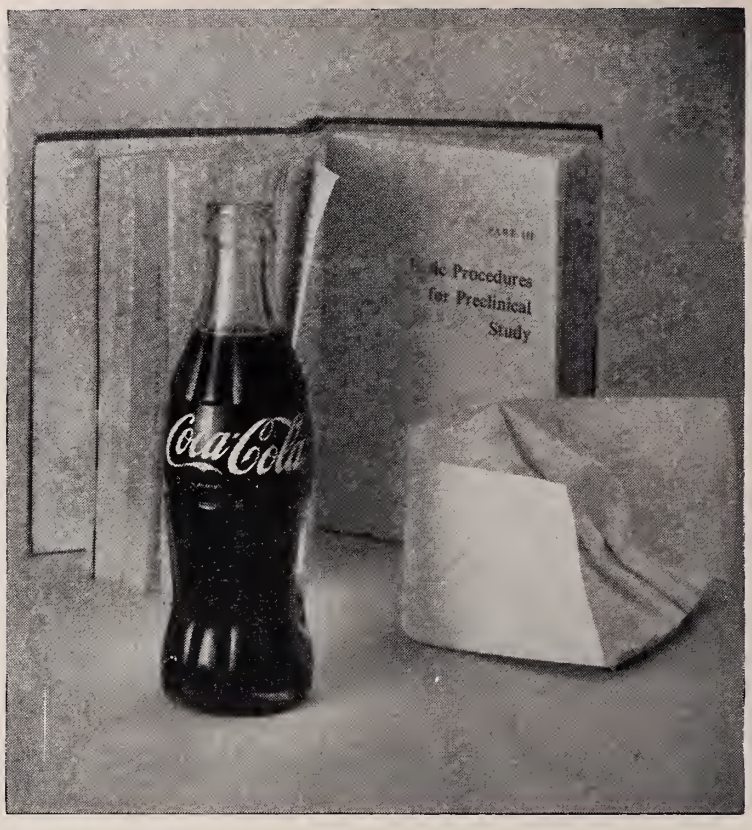
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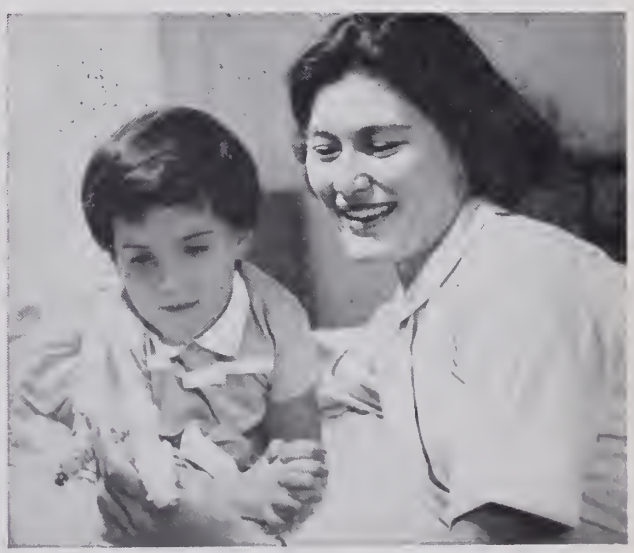
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1. Laughlin, H. P.: The Neuroses in Clinical Practice, Saunders, Philadelphia, 1956, pp. 448-481.

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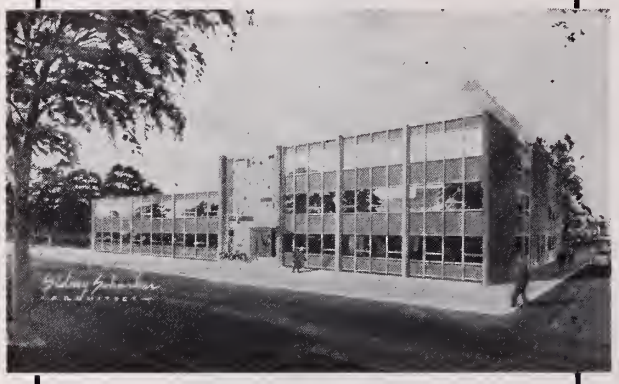
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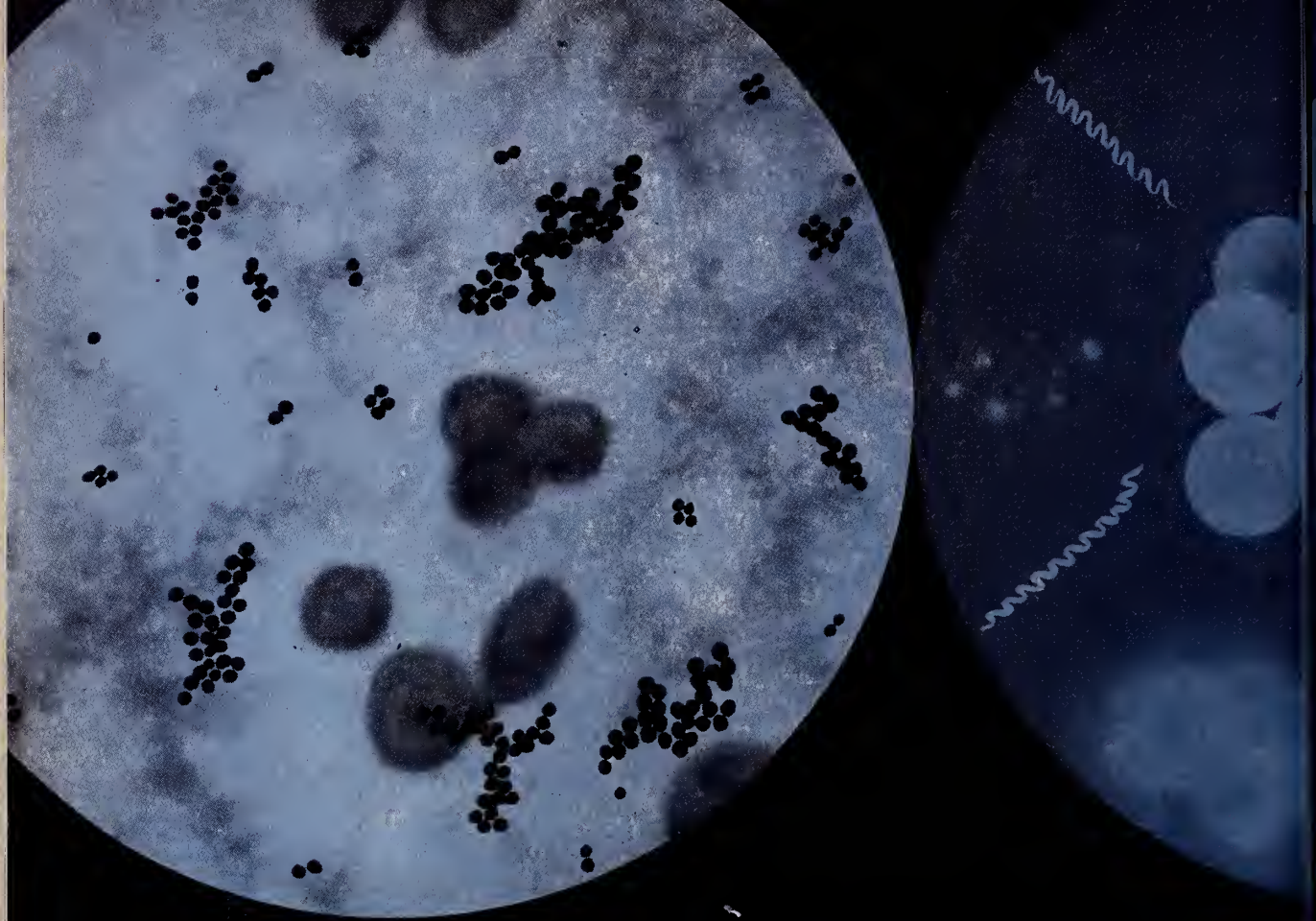
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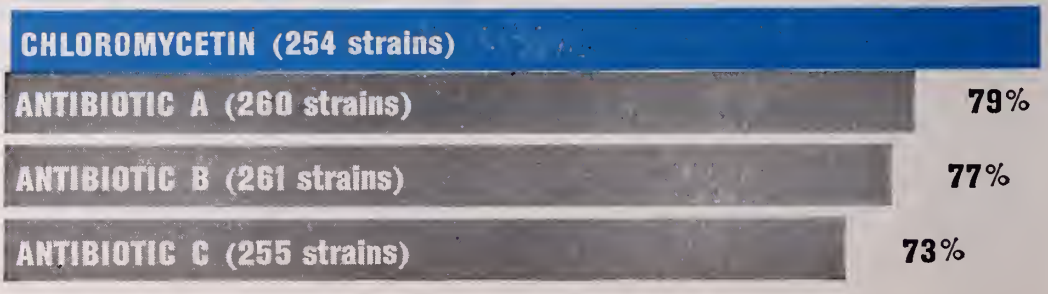


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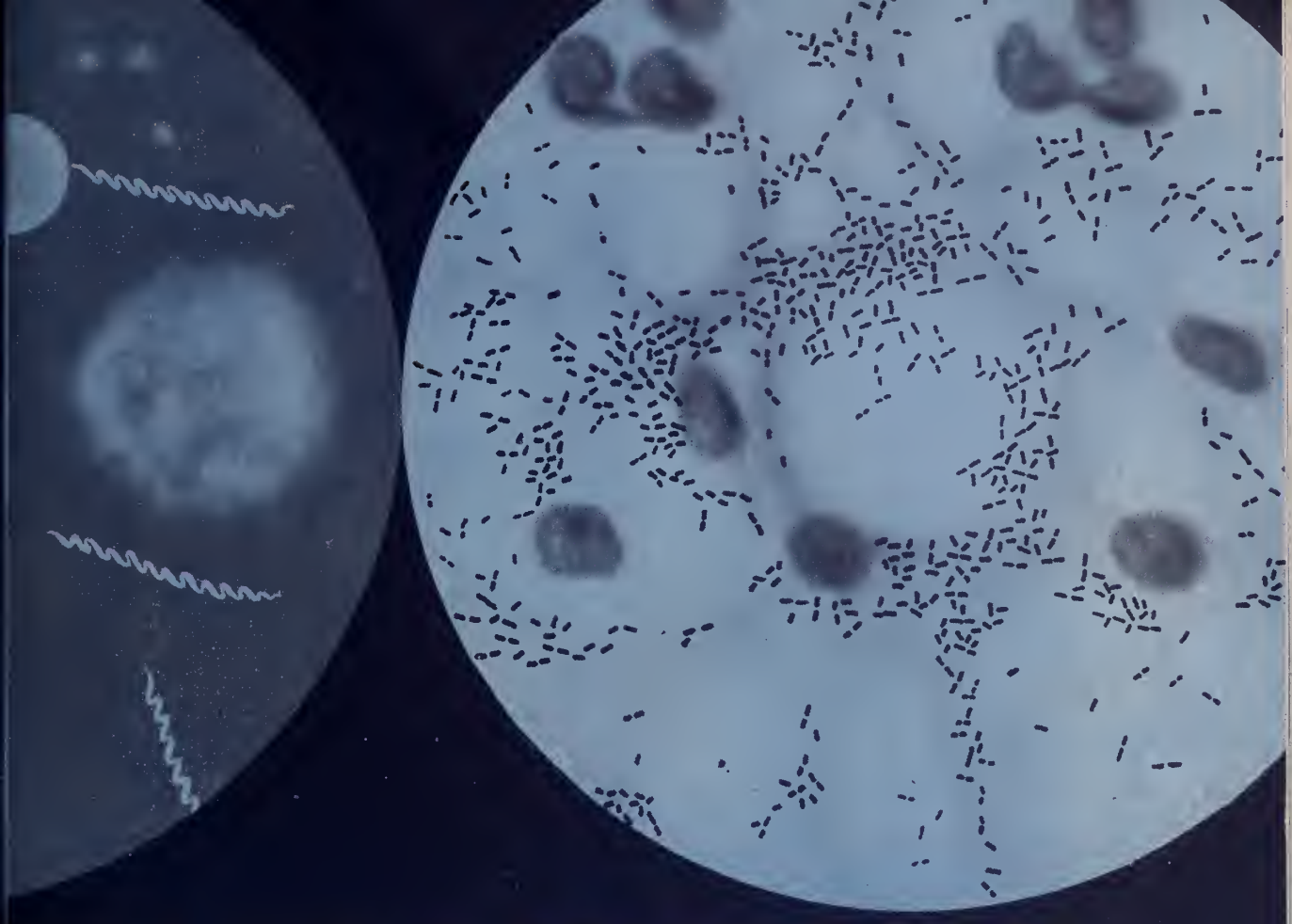
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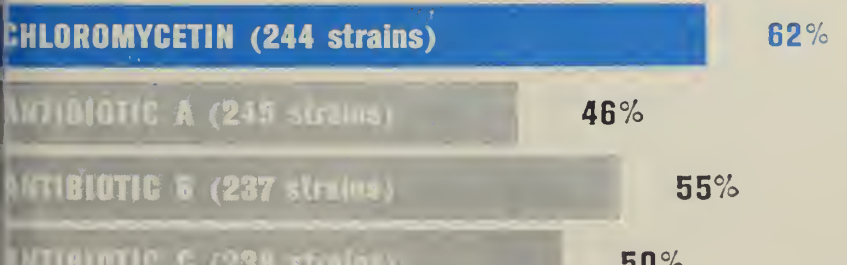
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Polydipsia	89	81.0
Weight loss	47	42.7
Polyphagia	28	25.4
Anorexia	16	14.5
Lethargy	14	12.7
Enuresis	7	6.4
Vomiting	5	4.5
Irritability	3	2.7
"Craving for sweets"	3	2.7
"Sticky diaper"	3	2.7
"Strong odor to urine"	2	1.8
Glycosuria	2	1.8
Hypoglycemia	2	1.8
Personality change	1	0.9
Boils	1	0.9
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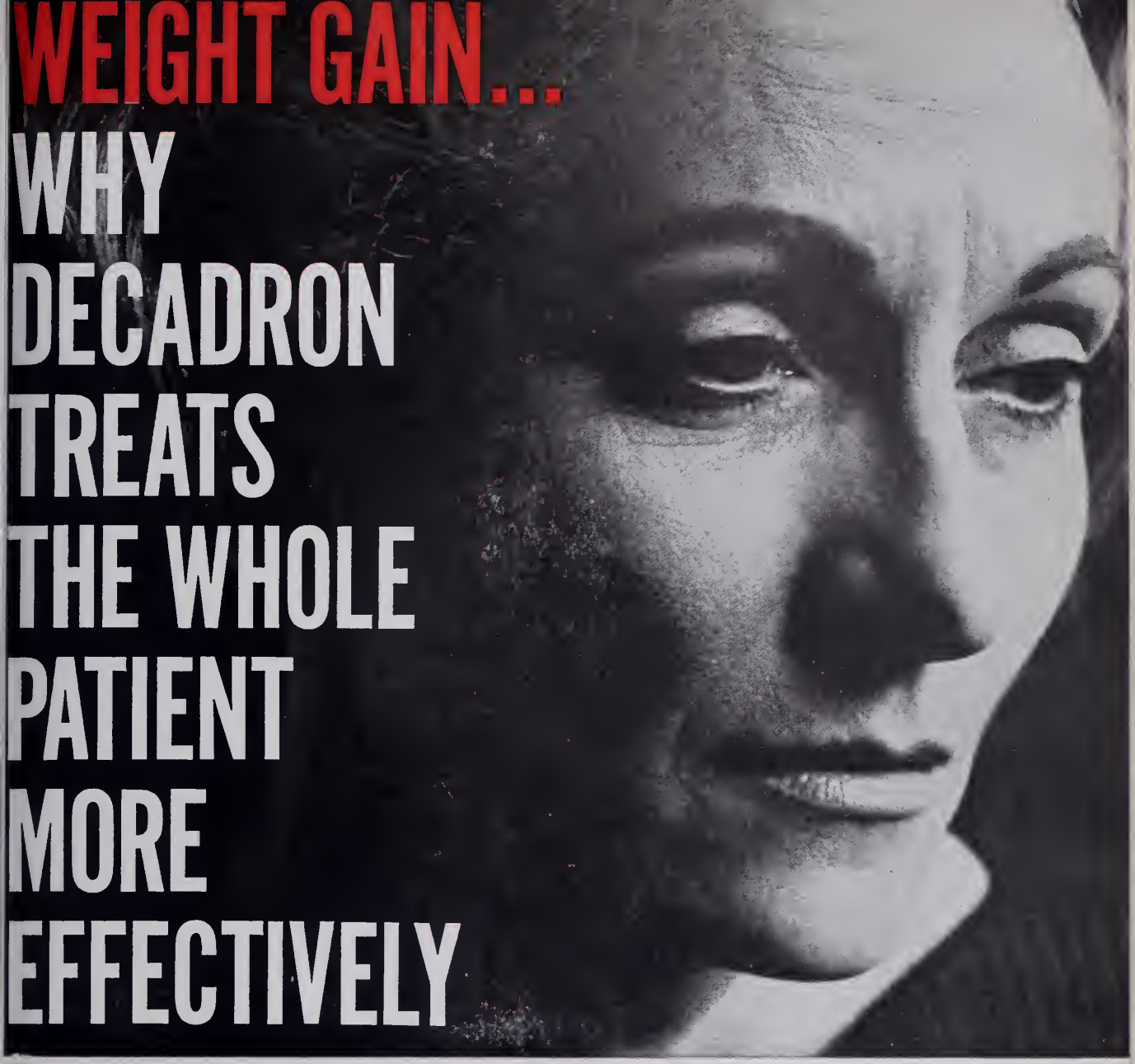
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References: 1. Bunim, J. J., et al.: Arthritis & Rheumatism *1*:313, 1958. 2. Silverman, H. I., and Urdang, A.: Am. Prof. Pharm. *25*:531, 1959. 3. Rudolph, J. A., and Rudolph, B. M.: Ann. Allergy *17*:710, 1959. 4. Spies, T. D., et al.: South. M. J. *51*:1066, 1958. 5. Galli, T., and Mannetti, C.: Minerva med. *50*:949, 1959. 6. Segal, M. S., et al.: Ann. Allergy *17*:413, 1959. 7. Duvenci, J., et al.: Ann. Allergy *17*:695, 1959.

Supplied: As 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100 and 1000. Also available as Injection DECADRON Phosphate.

Additional information on DECADRON is available to physicians on request.

DECADRON is a trademark of Merck & Co., Inc.

Decadron®

DEXAMETHASONE

"THE MOST POTENT STEROID"[1] WITH "THE LEAST NUMBER OF SIDE EFFECTS"[2]

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IN *ORAL* CONTROL OF PAIN

ACTS FASTER—usually within 5-15 minutes. **LASTS LONGER**—usually 6 hours or more. **MORE THOROUGH RELIEF**—permits uninterrupted sleep through the night. **RARELY CONSTIPATES**—excellent for chronic or bedridden patients.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

Also available — for greater flexibility in dosage — PERCODAN®-DEMI: The PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

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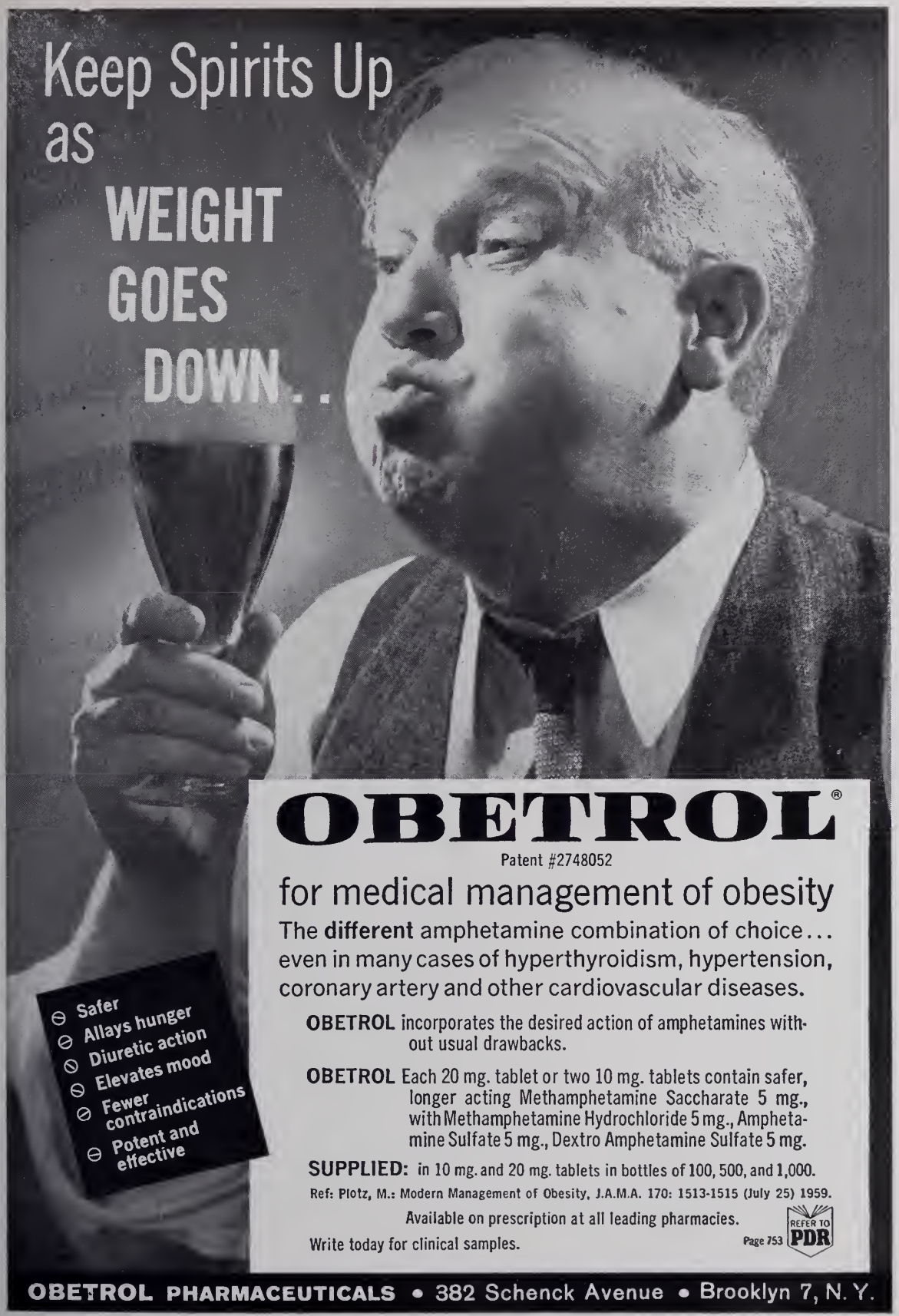
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Percodan® *Tablets*

Salts of Dihydrohydroxycodeinone and Homatropine, plus APC

FOR PAIN

*U.S. Pat. 2,628,185



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Patent #2748052

for medical management of obesity

The **different** amphetamine combination of choice... even in many cases of hyperthyroidism, hypertension, coronary artery and other cardiovascular diseases.

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SUPPLIED: in 10 mg. and 20 mg. tablets in bottles of 100, 500, and 1,000.

Ref: Plotz, M.: Modern Management of Obesity, J.A.M.A. 170: 1513-1515 (July 25) 1959.

Available on prescription at all leading pharmacies.

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REFER TO PDR Page 753

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Only Kent offers this remarkable combination:

FINEST NATURAL TOBACCOS
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Today—as before—for good smoking taste, it makes good sense to smoke Kent, because Kent satisfies your appetite for a real good smoke.

A Product of P. Lorillard Company—First with the finest cigarettes—through Lorillard Research!

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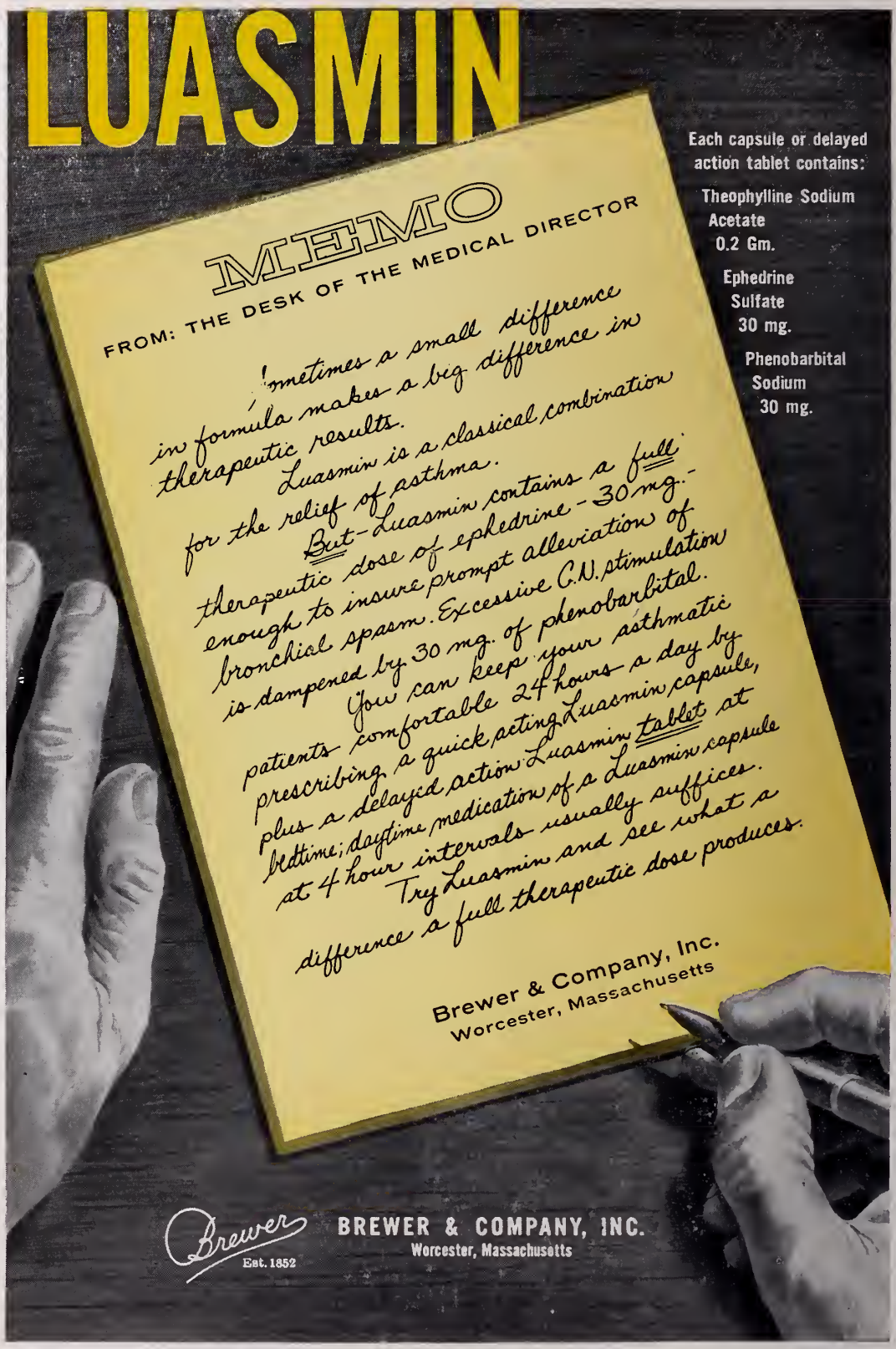
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S-413




LUASMIN
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FROM: THE DESK OF THE MEDICAL DIRECTOR
Sometimes a small difference in formula makes a big difference in therapeutic results.
Luasmin is a classical combination for the relief of asthma.
But-Luasmin contains a full therapeutic dose of ephedrine-30 mg.-enough to insure prompt alleviation of bronchial spasm. Excessive C.N.S. stimulation is dampened by 30 mg. of phenobarbital.
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Try Luasmin and see what a difference a full therapeutic dose produces.
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Each capsule or delayed action tablet contains:
Theophylline Sodium Acetate 0.2 Gm.
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OUTSTANDING 1-DOSE-A-DAY SULFA—*Rapid peak attainment* in 1 to 2 hours[1,2]... approximately one-half the time of other single-daily dose sulfas.[2] *High free levels*—as much as 95 per cent of circulating levels remaining in fully active unconjugated forms.[3] *Extremely low 2.7 per cent incidence of side effects* in a clinical study on 223 patients.[4] Includes *total* reactions (subjective and objective), all temporary and rapidly reversed. No crystalluria reported.

KYNEX Tablets, 0.5 Gm., bottles of 24 and 100. Dosage: Adults. 0.5 Gm. (1 tablet) daily following an initial first day dose of 1 Gm. (2 tablets).

KYNEX Acetyl Pediatric Suspension, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per tsp. (5 cc.). Bottles of 4 and 16 fl. oz.

New for acute G. U. infection AZO KYNEX Tablets (for q. i. d. dosage), 125 mg. KYNEX sulfamethoxypyridazine in the shell with 150 mg. phenylazodiaminopyridine HCl in the core.



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Sulfamethoxypyridazine Lederle

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378 (Nov.) 1956. 2. Boger, W. P.: In: Antibiotic Annual 1958-1959, Medical Encyclopedia, Inc., New York. 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959.

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1¼ Grs. Ea.
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Physicians, through ever increasing recommendation, have long demonstrated their confidence in the uniformity, potency and purity of Bayer Aspirin, the world's first aspirin.

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New GRIP-TIGHT CAP for Children's Greater Protection



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she calls it "nervous indigestion"

diagnosis: a wrought-up patient with a functional gastro-intestinal disorder compounded by inadequate digestion. **treatment:** reassurance first, then medication to relieve the gastric symptoms, calm the emotions, and enhance the digestive process. **prescription:** new Donnazyme—providing the multiple actions of widely accepted Donnatal® and Entozyme®—two tablets t.i.d., or as necessary.

Each Donnazyme tablet contains
—In the gastric-soluble outer layer: Hyoscyamine sulfate, 0.0518 mg.; Atropine sulfate, 0.0097 mg.; Hyoscine hydrobromide, 0.0033 mg.; Phenobarbital (1/8 gr.), 8.1 mg.; and Pepsin, N. F., 150 mg. **In the enteric-coated core:** Pancreatin, N. F., 300 mg., and Bile salts, 150 mg.

ANTISPASMODIC - SEDATIVE - DIGESTANT

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Maximal Absorption

Acid stable, highly soluble

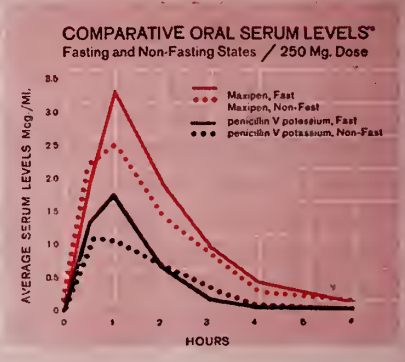
Maximal Blood Levels

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May be administered without regard to meals. However, highest absorption is achieved when taken just before or between meals.

Maximal Oral Indications

Indicated in infections caused by streptococci, pneumococci, susceptible staphylococci, and gonococci



*Based on 3294 individual serum antibiotic determinations. Complete details available on request.

DOSAGE: For moderately severe conditions, 125 to 250 mg. three times daily. For more severe conditions, 500 mg. as often as every four hours around the clock.

NOTE: To date, MAXIPEN has not shown less allergic reactions than older oral penicillins. Usual precautions regarding penicillin administration should be observed.

SUPPLIED: MAXIPEN TABLETS, scored, 125 mg. (200,000 units), bottles of 36; 250 mg. (400,000 units), bottles of 24 and 100 tablets. MAXIPEN FOR ORAL SOLUTION; reconstituted each 5 cc. contains 125 mg. (200,000 units), in 60 cc. bottles.

MAXIPEN, the orally maximal penicillin, is a triumph of man over molecule; a product of Pfizer Research

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Each of the babies pictured on this page was borne by a mother with a *documented* previous history of true habitual abortion, who was treated with DELALUTIN during the pregnancy leading to this birth

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SQUIBB HYDROXYPROGESTERONE CAPROATE

Improved Progestational Therapy



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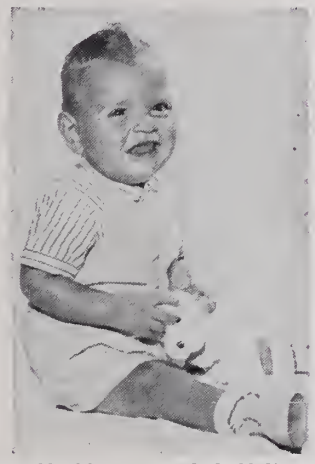
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DELALUTIN offers these advantages over other progestational agents

• long-acting sustained therapy • more effective in producing and maintaining a completely matured secretory endometrium • no androgenic effect • more concentrated solution requiring injection of less vehicle • unusually well-tolerated, even in large doses • fewer injections required • low viscosity makes administration easy

Complete information on administration and dosage is supplied in the package insert

Supply:
Vials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in benzyl benzoate and sesame oil.

Also available: DELALUTIN 2X in 5 cc. multiple-dose vials. Each cc. contains 250 mg. hydroxyprogesterone caproate in castor oil, preserved with benzyl alcohol.

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"DELALUTIN"® IS A SQUIBB TRADEMARK

The first synthetic penicillin available for general clinical use

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PEAK BLOOD LEVELS HIGHER THAN POTASSIUM PENICILLIN V

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IMPROVED ANTIBIOTIC ACTION FROM ISOMERIC COMPLEMENTARI

SUPPLY: SYNCILLIN TABLETS–250 mg. and SYNCILLIN TABLETS–125 mg.
SYNCILLIN FOR ORAL SOLUTION–60 ml. bottles–when reconstituted, 125 mg. per 5 ml.
SYNCILLIN FOR PEDIATRIC DROPS–1.5 Gm. bottles. Calibrated dropper delivers 125 mg.

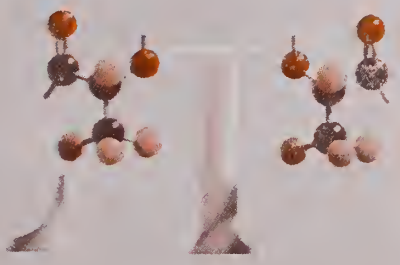




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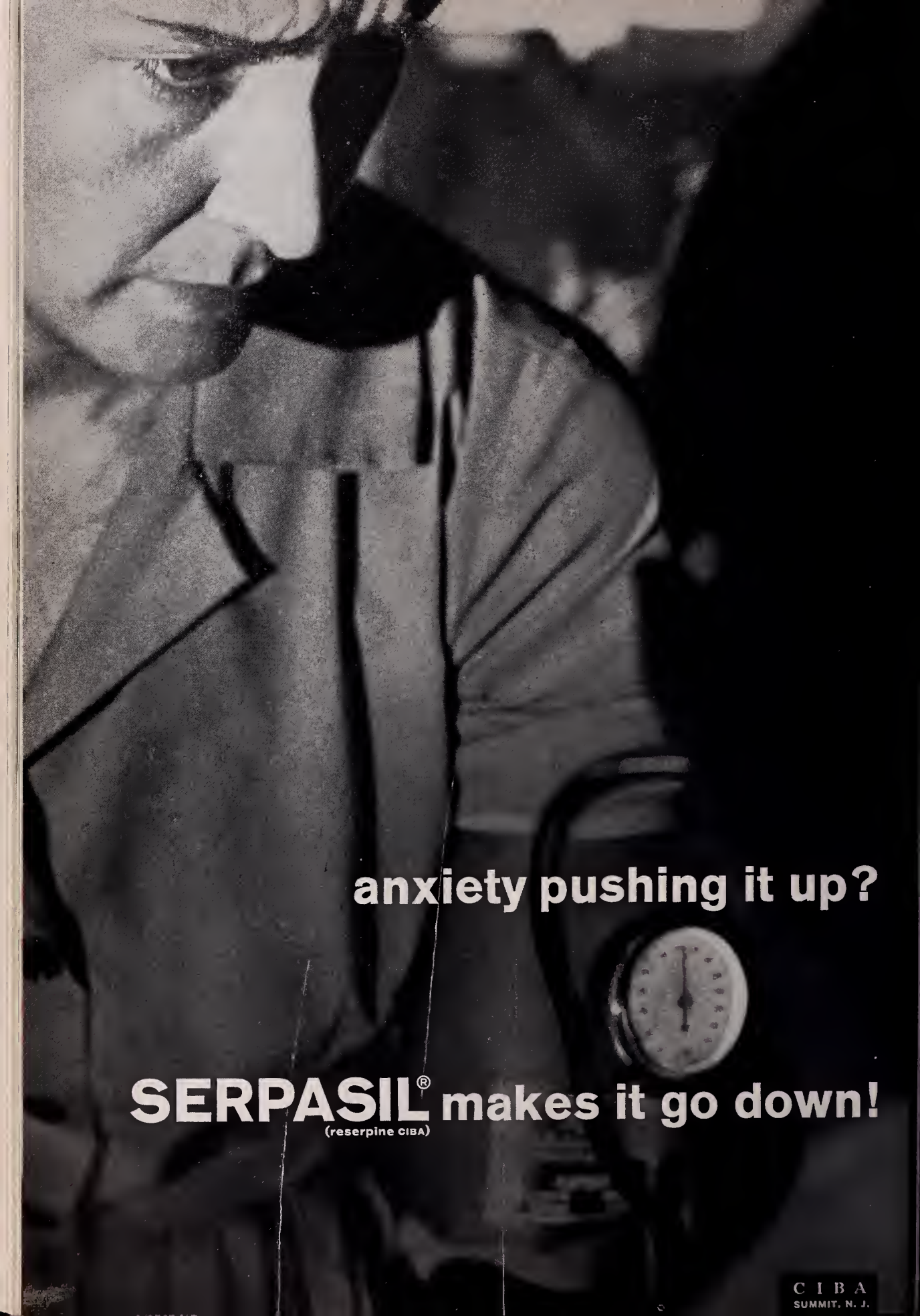
potassium phenethicillin (POTASSIUM PENICILLIN-152)

NTIBIOTIC	*REDUCED*	*SOME STAPH*
CTIVITY	*RATE OF*	*STRAINS MORE*
IRECTLY	*INACTIVATION*	*SENSITIVE TO*
ROPORTIONAL	*BY STAPH*	*SYNCILLIN*
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BRISTOL




anxiety pushing it up?
SERPASIL®
(reserpine CIBA)
makes it go down!
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51 to 49...it's a boy!





94 to 6 BONADOXIN® stops morning sickness

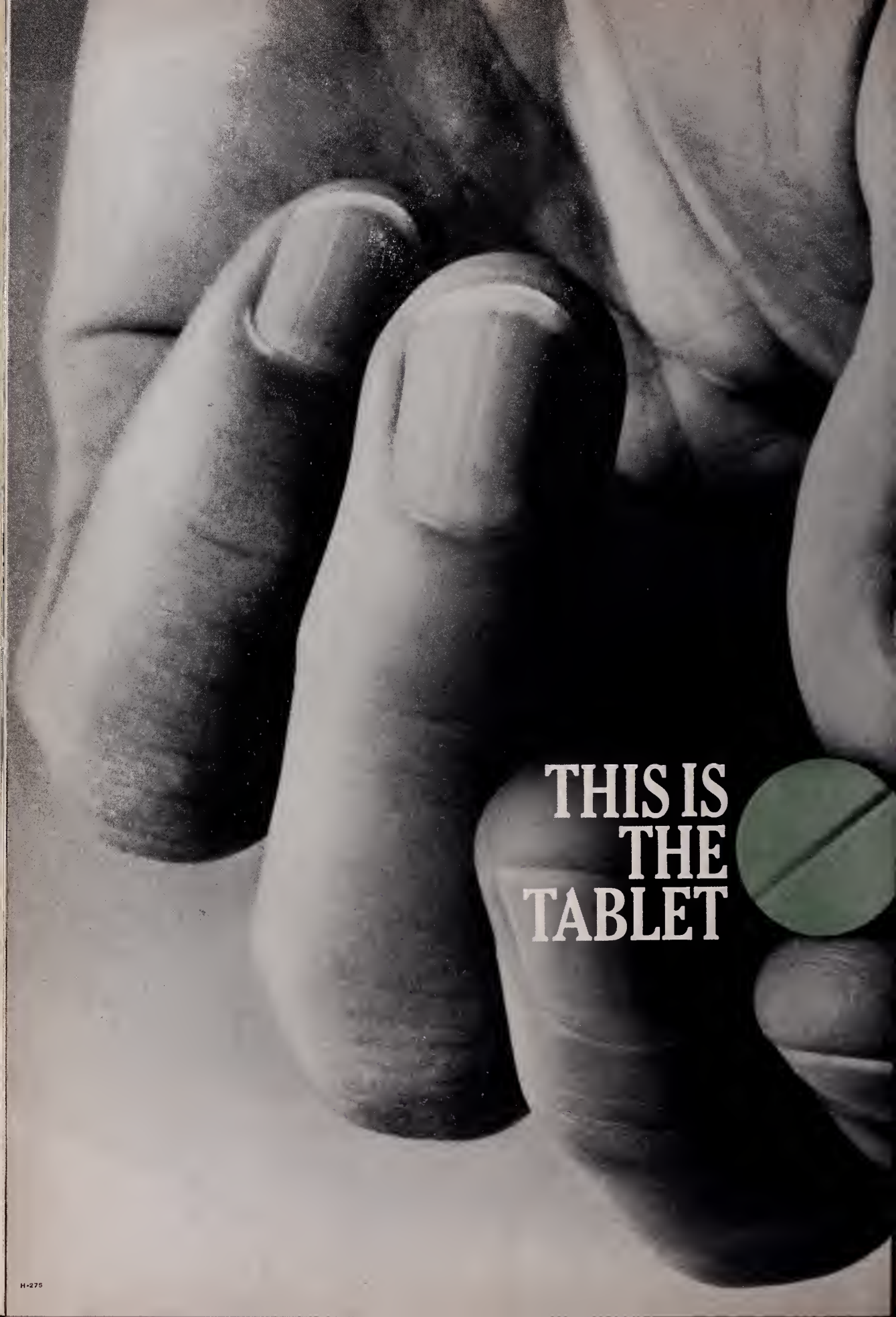
When she asks "Doctor, what will it be?" you can either flip a coin or point out that 51.25% births are male.[1] But when she mentions morning sickness, your course is clear: BONADOXIN.

For, in a series of 766 cases of morning sickness, seven investigators report excellent to good results in 94%.[2] More than 60 million of these tiny tablets have been taken. The formula: 25 mg. Meclizine HCl (for antinauseant action) and 50 mg. Pyridoxine HCl (for metabolic replacement). Just one tablet the night before is usually enough.

BONADOXIN—DROPS and Tablets—are also effective in infant colic, motion sickness, labyrinthitis, Meniere's syndrome and for relieving the nausea and vomiting associated with anesthesia and radiation sickness. See PDR p. 795.

1. Projection from Vital Statistics, U.S. Government Dept. HEW, Vol. 48, No. 14, 1958, p. 398.
2. Modell, W.: Drugs of Choice 1958-1959, St. Louis, C. V. Mosby Company, 1958, p. 347.

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THIS IS
THE
TABLET



ALPEN is the oral penicillin that provides on a fasting stomach peak antibiotic blood levels approximately twice as high as oral potassium penicillin V... and significantly higher than I. M. penicillin G.

Some strains of staphylococci resistant to other penicillins exhibit in vitro sensitivity to potassium phenethicillin.

ALPEN has greater freedom from the G. I. sequelae (overgrowth of resistant flora) sometimes observed with broad spectrum -mycins.

ALPEN gives much higher antibiotic levels within the first hour of ingestion by the well-tolerated oral route.

WHEN TO USE ALPEN Recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci.

HOW TO USE ALPEN Depending on the severity of the infection, 125 mg. (200,000 units) or 250 mg. (400,000 units) three times daily may be used. In more severe or stubborn infections, a dosage of 500 mg. (800,000 units) t.i.d. may be employed. In beta hemolytic streptococcal infections, treatment should be continued for at least ten days.

PRECAUTIONS The usual precautions in the administration of oral penicillin should be observed. For further details see package literature.

Tablets: 125 mg. and 250 mg., bottles of 25 and 100. Powder for Oral Solution (lemon-lime flavored), 1.5 Gm. bottle (125 mg. per 5 cc. teaspoonful).

this is the tablet that gives higher peak antibiotic blood levels

HIGHER THAN I. M. PENICILLIN G
HIGHER THAN POTASSIUM PENICILLIN V

ALPEN

ALPEN™—potassium phenethicillin

Schering

Lifts depression..



You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in two or three days.* She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

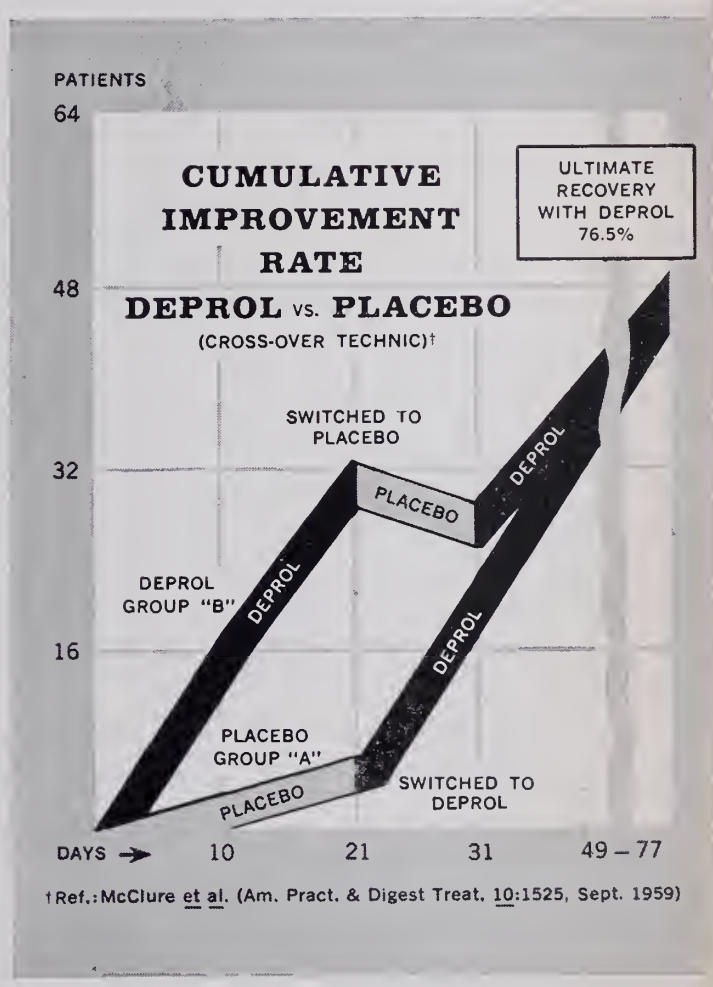
Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood — no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient — *they often aggravate anxiety and tension.* And although amphetamine-barbiturate combinations may counteract excessive stimulation — *they often deepen depression.*

In contrast to such "seesaw" effects, Deprol lifts depression as it calms anxiety — both at the same time.

Acts swiftly — the patient often feels better, sleeps better, within two or three days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly — often within two or three days.

Acts safely — no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function — frequently reported with other antidepressant drugs.



†Ref.: McClure et al. (Am. Pract. & Digest Treat. 10:1525, Sept. 1959)

BIBLIOGRAPHY *(11 clinical studies, 764 patients):*

1. Alexander, L. (35 patients): Chemotherapy of depression — Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **4.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **5.** Landman, M. E. (50 patients): Choosing the right drug for the patient. Submitted for publication, 1960. **6.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression—New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **7.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **8.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **9.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **10.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprabamate-benactyzine hydrochloride combination (Deprol). Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **11.** Splitter, S. R. (84 patients): The care of the anxious and the depressed. Submitted for publication, 1959.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

Deprol®

WALLACE LABORATORIES / *New Brunswick, N. J.*

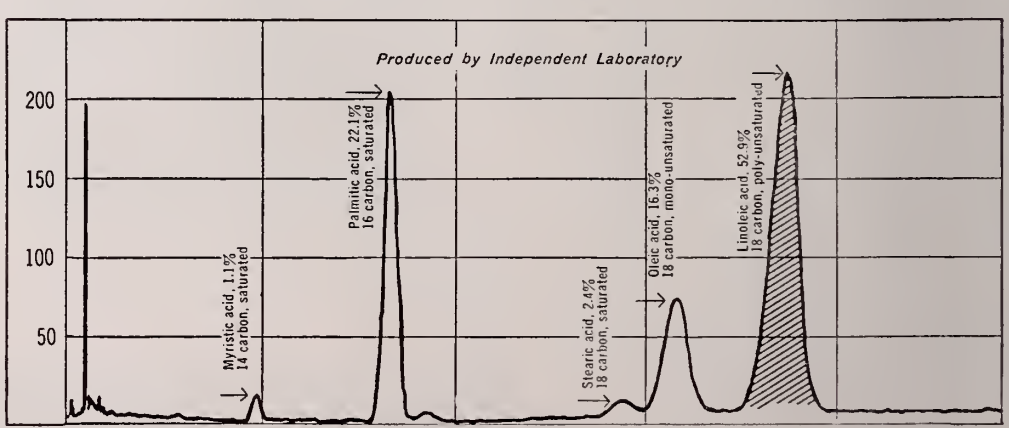
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"It is now well recognized that serum cholesterol levels in man can be lowered by the judicious substitution of one type of dietary fat for another. However, it is relevant to inquire whether a patient can be assured that such a radical change in his dietary habits will prevent coronary occlusion or a cerebral vascular accident. This question must unfortunately be answered in the negative, for it has not been proved that lowering the level of serum cholesterol will prevent either the occurrence or the end-results of atherosclerosis. At the present time, clear proof of this proposition still seems many years away. Nevertheless, there are many reasons for believing that there is some connection between cholesterol metabolism and atherosclerosis, and, while waiting for elucidation of this relationship by laboratory workers, it seems justifiable to apply certain dietary procedures that are theoretically harmless and possibly beneficial."

Excerpted from J.A.M.A., Aug. 29, 1959

GAS CHROMATOGRAPH OF WESSON—the pure vegetable oil



Note High Linoleic Acid Content, 52.9% Poly-unsaturated.



FREE *Wesson recipes, available in quantity for your patients, show how to prepare meats, seafoods, vegetables, salads and desserts with poly-unsaturated vegetable oil. Request quantity needed from The Wesson People, Dept. N., 210 Baronne St., New Orleans 12, La.*

WESSON'S IMPORTANT CONSTITUENTS

Wesson is 100% cottonseed oil . . . winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
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Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

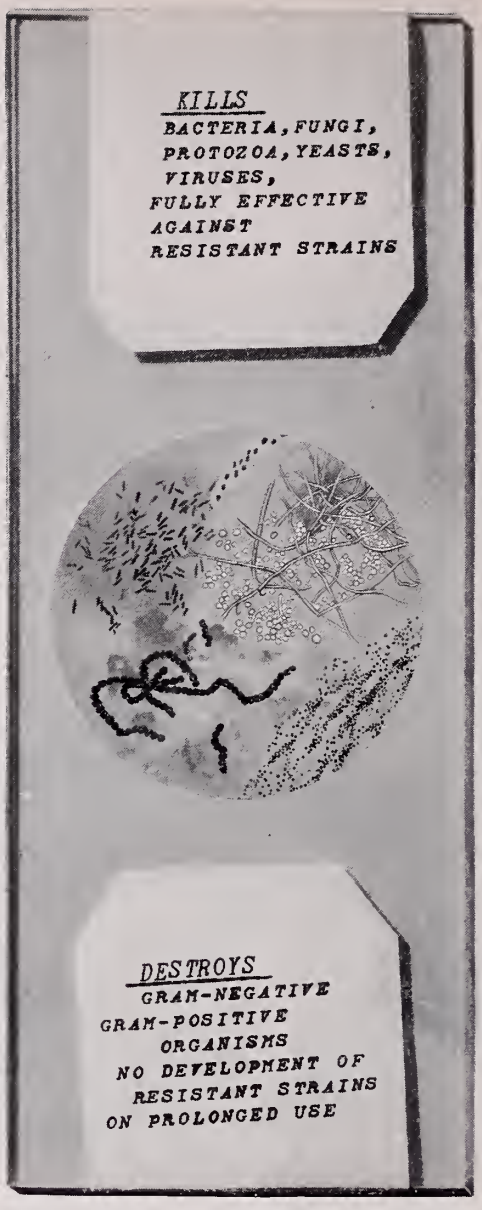
Each pint of Wesson contains 437-524 Int. Units of Vitamin E

Where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen, Wesson is unsurpassed by any readily available brand.

To be effective, a diet must be *eaten* by the patient. The majority of housewives prefer Wesson,* particularly by criteria of odor, flavor (blandness) and lightness of color.

Uniformity you can depend on. Wesson has a poly-unsaturated content better than 50%. Only the lightest cottonseed oils of highest iodine number are selected for Wesson, and no significant variations in standards are permitted in the 22 exacting specifications required before bottling.

*Reconfirmed by recent tests against the next leading brand with brand identifications removed, among a national probability group.



KILLS THEM ALL

IN TOPICAL INFECTIONS, regardless of etiology, BETADINE OINTMENT destroys all pathogens present. BETADINE OINTMENT provides a protective barrier against invading pathogens, relieves pain, applies easily, and may be bandaged. Its characteristic color indicates continuing germicidal protection. **Yet, BETADINE OINTMENT is nonsensitizing, nonirritating, and nontoxic to skin tissue.**

INDICATIONS: Primary and secondary skin infections including pyoderma, mycotic and bacterial infections, eczema, furunculosis, minor burns, as well as staph. aureus and pseudomonas infections.

ADMINISTRATION: apply liberally over affected area as often as needed, bandage if desired.

SUPPLIED: one ounce tube.

BETADINE™ OINTMENT

(ACTIVE INGREDIENT: POVIDONE IODINE*)

Topical Pathogenicide... Kills Pathogens On Contact

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World-wide record of effectiveness—over 200 laboratory and clinical papers from 14 countries.
Widest latitude of safety and flexibility—no serious adverse clinical reaction ever documented.
Chemically distinct among tranquilizers—not a phenothiazine or a meprobamate.
Added frontiers of usefulness—antihistaminic; mildly antiarrhythmic; does not stimulate gastric secretion.

Special Advantages	Supportive Clinical Observation	...and for additional evidence
IN CHILDREN unusually safe; tasty syrup, 10 mg. tablet	"...Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...." Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958.	Bayart, J.: Acta paediat. belg. 10:164, 1956. Ayd, F. J., Jr.: California Med. 87:75 (Aug.) 1957. Nathan, L. A., and Andelman, M. B.: Illinois M. J. 112:171 (Oct.) 1957.
IN ELDERLY PATIENTS well tolerated by debilitated patients	"...seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. 7:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. 8:1584 (Oct.) 1957. Negri, F.: Minerva med. 48:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics 11:312 (July) 1956.
IN ALLERGIC PATIENTS useful adjunctive therapy for asthma and dermatosis; particularly effective in urticaria	"All [asthmatic] patients reported greater calmness and were able to rest and sleep better...and led a more normal life....In chronic and acute urticaria, however, hydroxyzine was effective as the sole medicament." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.	Eisenberg, B. C.: J.A.M.A. 169:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. 64:2239 (Dec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. 50:1282 (Oct.) 1957.
IN HYPEREMOTIVE ADULTS does not impair mental acuity	"...especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. 45:549 (Nov.) 1958. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. 169:379 (June) 1956.

SUPPLIED: Tablets, 10 mg., 25 mg., 100 mg.; bottles of 100. Syrup (10 mg. per tsp.), pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules.

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Triamcinolone Acetonide 0.1%, Neomycin Sulfate 0.35% 15 cc. Push-button dispenser

References: 1. Kanof, N. B., and Blau, S.: *New York J. Med.* 59:2184 (June 1) 1959.
2. Smith, J. C., Jr.; Zawisza, R. J., and Blank, H.: *A.M.A. Arch. Dermat.* 78:643 (Nov.) 1958.

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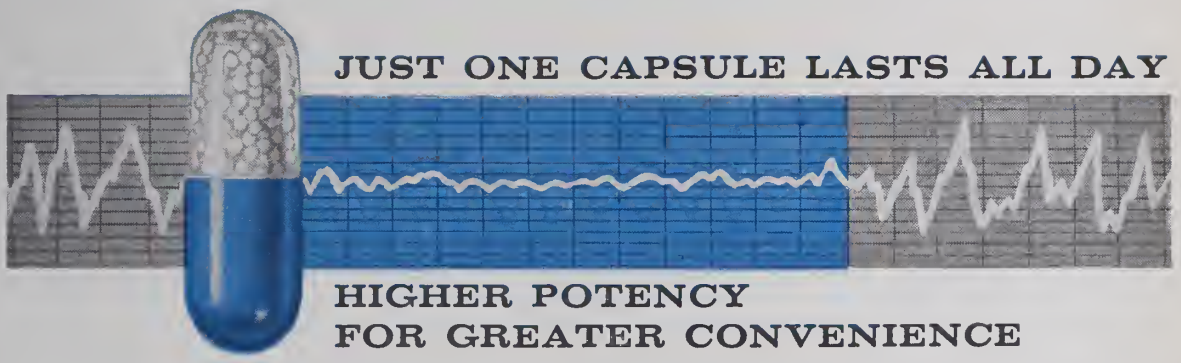
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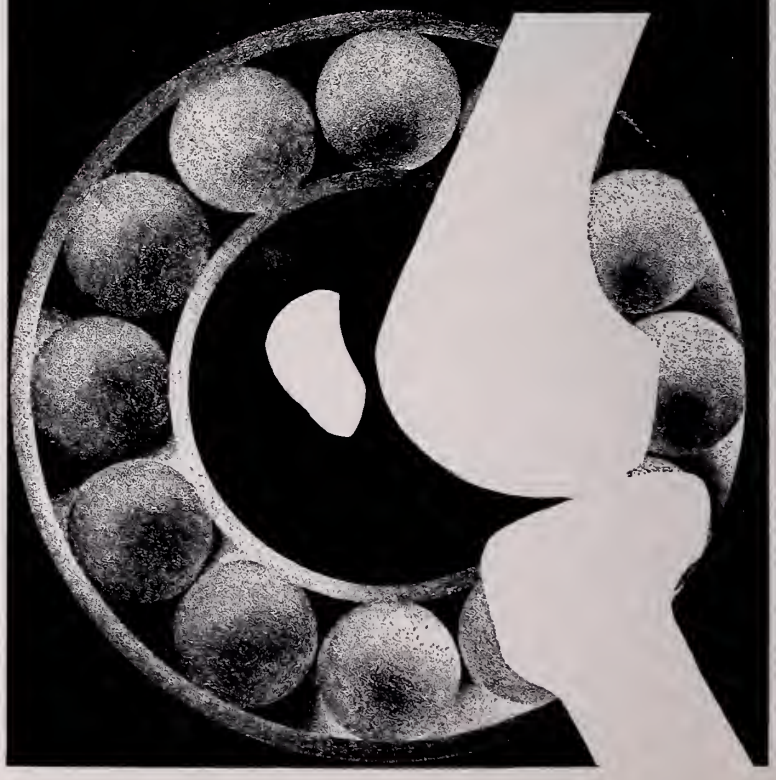
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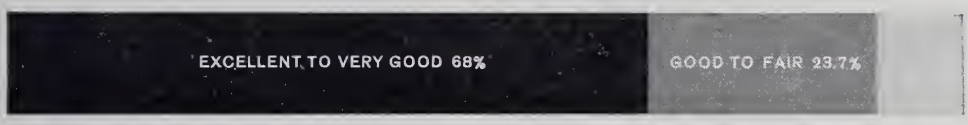
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In 100 consecutive patients with the low back syndrome, Kestler[1] reported that particularly gratifying was the ability of SOMA "to relax muscular spasm, relieve pain, and restore normal movement, thus speeding recovery in a large majority of the patients."

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NOTABLE SAFETY—extremely low toxicity; no known contraindications; side effects are rare; drowsiness may occur, usually at higher dosage

RAPID ACTION—starts to act quickly **SUSTAINED EFFECT**—relief lasts up to 6 hours

EASY TO USE—usual adult dosage is one 350 mg. tablet 3 times daily and at bedtime

SUPPLIED—as white, coated, 350 mg. tablets, bottles of 50; also available for pediatric use: 250 mg., orange capsules, bottles of 50

1. Kestler, O.: In The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. 2. Berger, F. M.; Kletzkin, M.; Ludwig, B. J.; Margolin, S., and Powell, L. S.: J. Pharm. Exp. Ther. *127*:66 (Sept.) 1959. 3. Spears, C. E. and Phelps, W. M.: Arch. Pediat. *76*:287 (July) 1959. 4. Phelps, W. M.: Arch. Pediat. *76*:243 (June) 1959. 5. Friedman, A. P.; Frankel, K., and Fransway, R. L.: Papers presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 6. Kuge, T.: Unpublished reports. 7. Ostrowski, J. P.: Orthopedics *2*:7 (Jan.) 1960.

Literature and samples on request

Also available on request: The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. (185 pages)

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TRICHOTINE is the first major douche to contain sodium lauryl sulfate, a detergent of the highest order of efficiency. TRICHOTINE penetrates and dissolves the viscid film covering the vaginal mucosa; gets down in the rugal folds, carrying medication directly to the mucosa and the invading organisms.

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of many micro-organisms. "The douche solution is an effective agent against Trichomonas Vaginalis, Monilia Albicans, anaerobic organisms including a potent strain of streptococci that sometimes cause severe infections, and other non-specific vaginal micro-organisms."[1]

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1. Karnaky, K.J.: Med. Record and Annals, Houston 46:296 (Nov. 1952).

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ALTAFUR in surgical (soft tissue) infections

In a series of 159 patients with various types of surgical infections (cellulitis, abscess, wound infections), ALTAFUR was employed with eminently satisfactory results. The incidence and magnitude of surgery were considerably reduced in these cases, and when surgical intervention was necessary it could be delayed until the inflammatory process had receded or become localized.

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Prigot, A.; Felix, A. J., and Mullins, S.: Paper presented at the Symposium on Antibacterial Therapy, Michigan and Wayne County Academies of General Practice, Detroit, September 12, 1959 (published Nov. 1959)

*Experimental dosage (see dosage recommendations adjacent)

bright new star
in the antibacterial firmament

ALTAFUR®

brand of furaltadone

the first nitrofuran effective orally
in systemic bacterial infections

- Antimicrobial range encompasses the majority of common infections seen in everyday office practice and in the hospital
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more complete than antihistamines alone...more thorough than nose drops or sprays

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Phenylpropanolamine HCl	50 mg.
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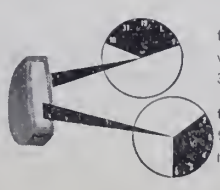
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TRIAMINIC SYRUP each teaspoonful (5 ml.) provides ¼ the formulation of the Triaminic Tablet.

References: 1. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. 2. Lhotka, F. M.: Illinois M. J. 112 259 (Dec.) 1957. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Fuchs, M.; Bodi, T.; Mallen, S. R.; Hernando, L., and Moyer, J. H.: Antibiotic Med. & Clin. Ther. 7:37 (Jan.) 1960. 5. Halpern, S. R., and Rabinowitz, H.: Ann. Allergy 18:36 (Jan.) 1960.

Relief is prompt and prolonged because of this special timed-release action

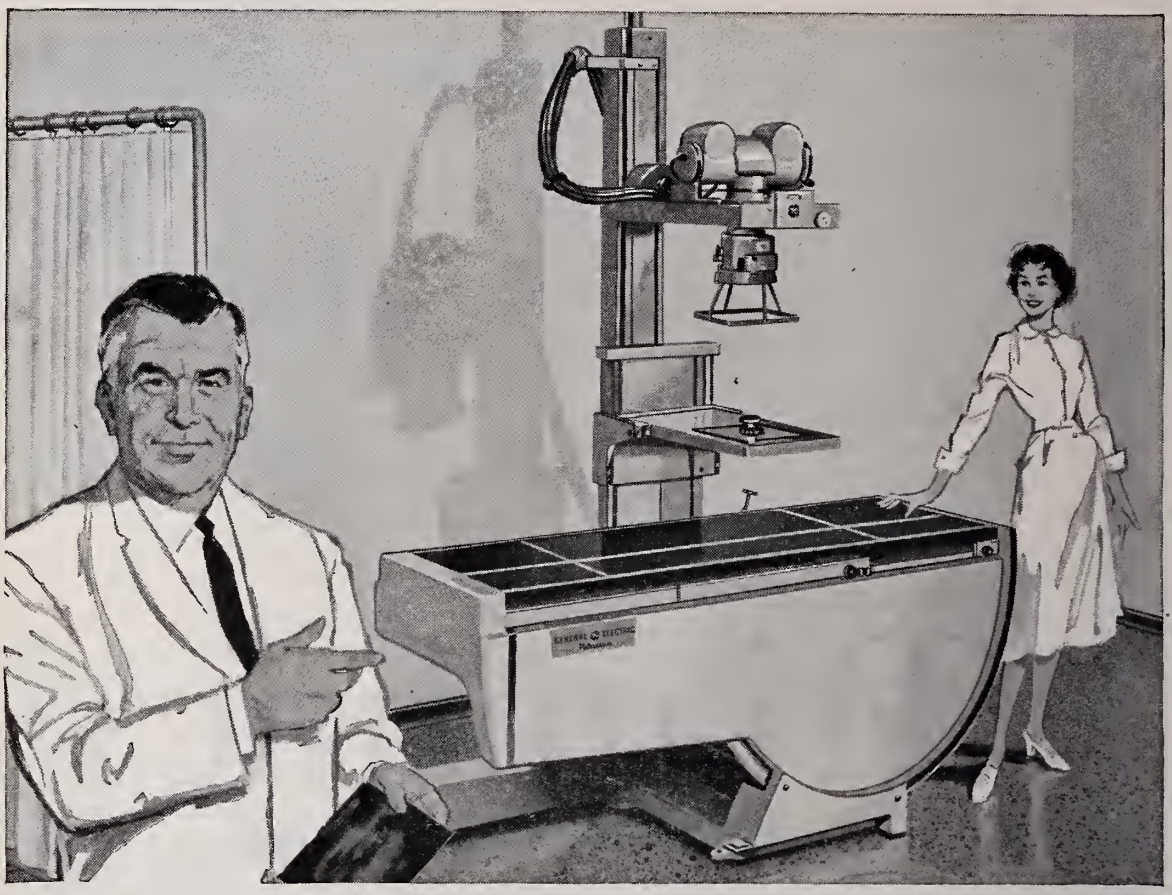


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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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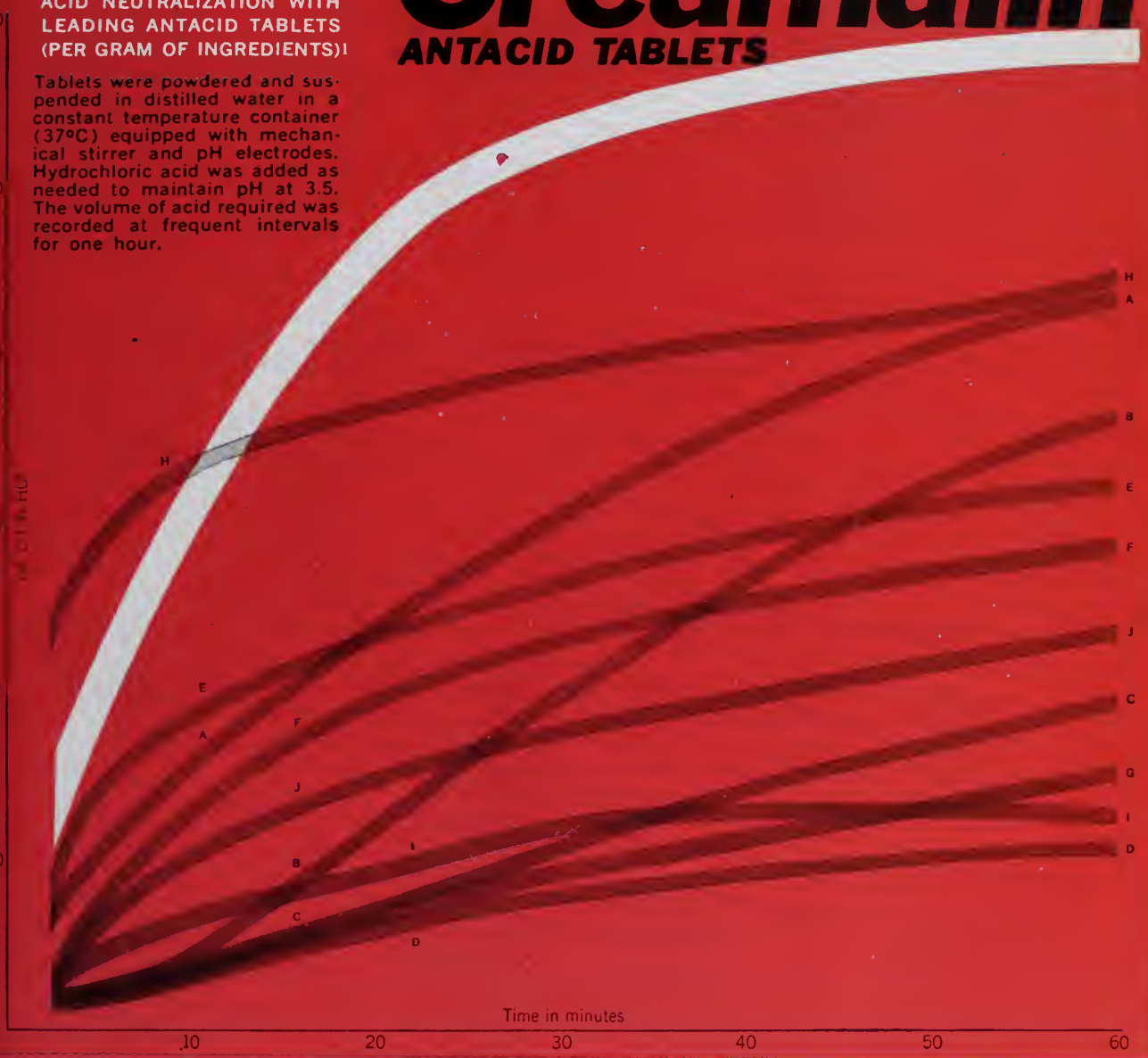
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1. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:380, July, 1959. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:384, July, 1959.

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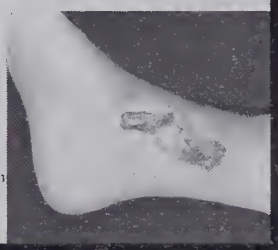


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References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

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1. Griffith, R. S.: Comparison of Antibiotic Activity in Sera Following the Administration of Three Different Penicillins, Antibiotic Med. & Clin. Therapy, 7:No. 2 (February), 1960.

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Communications Breakdown

We doctors are perpetually astonished—and hurt—at the public's apparent demand for more Government intervention in medicine. Under our system, we have given the American people the best medical care in the world. Why then, this fever for a change? One reason, often suggested, is that something has distorted the image of the doctor from the traditional friend in need, to something brisker and colder. Presumably we have failed to communicate to the public.

What has happened? For one thing, we are reluctant to publicize ourselves as individuals. We don't boast of cures or announce the names of our prominent patients. Doctors don't solicit or publish testimonials—either as individuals or for the whole profession. In our caution about new plans for medical care for the aged, for instance, we give the impression of being disinterested, although, as individuals our whole history shows that this cannot be true. We sweated out our own plans for medical care insurance. They served as pilots for many commercial plans; yet somehow instead of communicating our pioneer venture in health insurance we have branded ourselves as opposed to it. We must be interested in people or we wouldn't be physicians; yet we have failed to communicate warmth of interest. Our fees are modest compared to what the public is prepared to pay for cosmetics, automobiles, vacations or TV sets. Yet we have not communicated this, and instead strike some people as gougers. Experts in communication (to be frank, let's call them advertisers or promoters) are called on to tell the story for industries, for politicians, for labor leaders.

Is it not time for us to match modern technics of communication?

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Financing of Drug Promotion

Newspaper-reading patients occasionally invade the doctor's office with a clipping from the financial section. The story is that the Great East-West Pharmacal Laboratories, Inc. is about to place on the market a new week-end preparation which will combine aphrodisiac and anti-hangover properties in one slow-release capsule. If the research on hamsters proves successful, the company will float a million-dollar bond issue to raise capital for development, production and promotion.

We are all used to having indignant patients ask us why we don't keep up with *Reader's Digest*—but this is a new wrinkle. Now we have to keep up with financial prospectuses.

Strictly speaking, the company can plead "non vult" on the grounds that they are not promoting the medical value of the drug at this stage. Indeed, they can point virtuously to the fact that their literature admits that further research is necessary and contemplated. And they are not going to promote the new capsule unless research has validated it.

This virtuous defense may be true—but the actual effect of the news release is to suggest that here, indeed, is a new panacea, awaiting only the flow of money into the company's treasury. Patients certainly get that impression. And when the doctor says he never heard of Week-end-Schmeissen, the patient thinks that his practitioner must be an old fuddy-duddy.

Some indignant MDs now say that a pharmaceutical company that indulges in this type of promotion may have forfeited the goodwill of the practitioner and should be told so. While this may seem a bit drastic, there is some justification in such a reaction.

To be sure, we do not want to interfere with the development of a financial prospectus. But when the promotion has so clear a medical practice angle, we do have a right to ask for some restraint. What is unethical in a direct sales pitch does not become ethical when printed in a financial prospectus.

The Long View of Blue Shield

If you aren't too sure just what Blue Shield means to medicine—and to you and me—then imagine what the economics and the sociology of medical practice would be like without it.

Remember first that most Blue Shield Plans were organized by local units of organized medicine 15 or 20 years ago. Medicine then faced an urgent popular demand for some mechanism through which people could prepay unpredictable medical care costs. The insurance companies doubted that medical bills could be safely covered by insurance methods. They did not think that patients would ever be able to get together voluntarily on any workable prepayment plan.

But America's physicians—aided by free labor, free industry and the genius of American free enterprise—solved a complex nation-wide social problem by voluntary action.

Blue Shield is the one prepayment plan exclusively devoted to the common interests of patient and doctor. It's "nonprofit"—which means that the profits belong to the subscriber; and indeed they are returned to him in terms of broader services covered and more adequate payments for his doctor's services when he needs them. Blue Shield serves all segments of the community, not just those who offer the best prospect of profitable underwriting.

Physicians are voluntarily accepting Blue Shield payments in full payment of services required by subscribers in specified income brackets, recognizing that in Blue Shield—and *only* in Blue Shield—the payment schedules reflect the profession's own evaluations of its services and procedures.

Blue Shield is the greatest contribution American medicine has ever made in the economic sphere. It is dedicated to the preservation of a system that the profession and the people of this country clearly want to preserve.

William J. Dougherty, M.D., M.P.H.

David P. Hammond

Trenton

Syphilis Resurgence:*

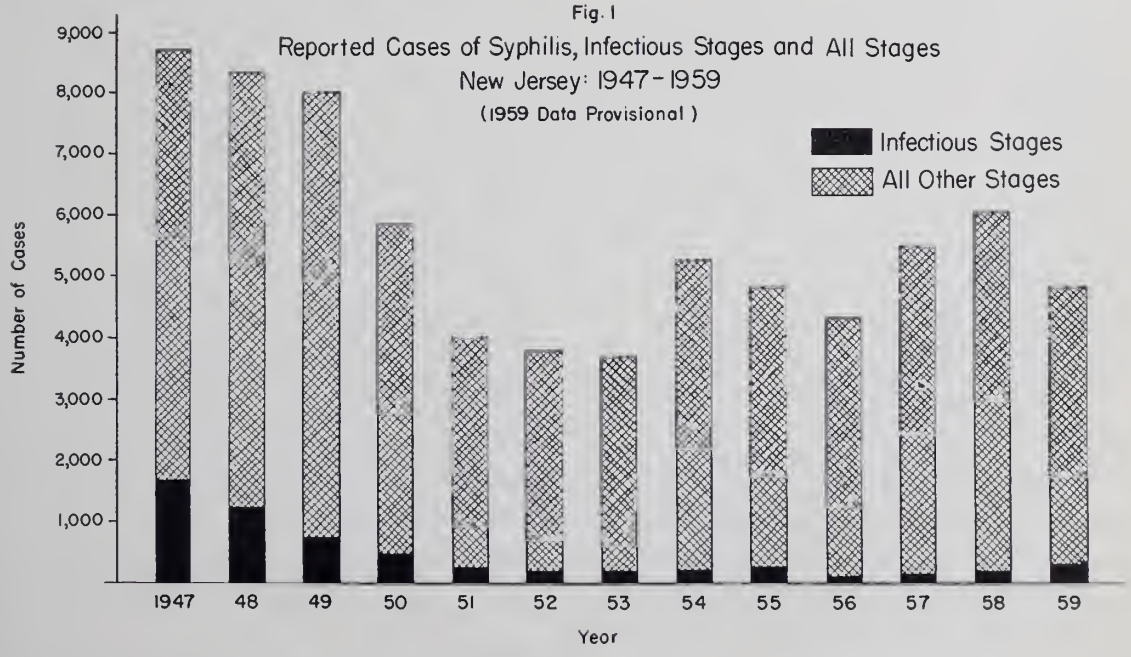
A New Epidemiologic Challenge

An old enemy returns. The number of infectious cases in New Jersey was 92 in 1956. But in 1959 it skyrocketted to 301. The Director of our State's Division of Preventable Diseases here discusses the implication of this resurgence.

The current venereal disease control program in the United States consists principally of local, state, and federal cooperative efforts in casefinding through epidemiology, serologic screening, and education. It has evolved from the massive campaign launched in 1939 following federal legislation authorizing substantial grants-in-aid for venereal disease control work. In the face of many obstacles, former Surgeon General Thomas Parran succeeded in

*Dr. Dougherty is Director of Preventable Diseases, New Jersey State Department of Health. Mr. Hammond is a Health Program Representative, U. S. Public Health Service.

Fig. 1



establishing a coordinated national program of state and local control activities and in attracting sufficient attention to the menace of uncontrolled syphilis to secure popular support for vigorous control measures. Additional impetus came with our entry into World War II. Control activity has been sustained at a high level in the ensuing years, while improvements in therapy and casefinding, demographic dynamics, and an overall lowering of incidence have required modification of control technics.

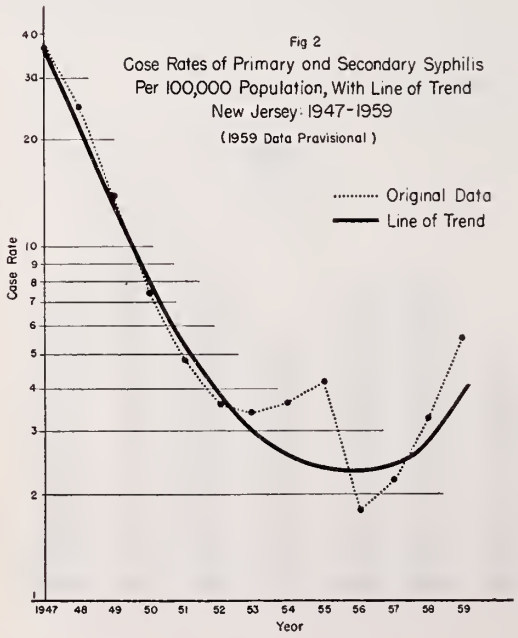
The general decline in reported cases of syphilis in the United States from 1947 to 1955 presented an encouraging prospect for effective control of syphilis within a few years. The experience of New Jersey from 1947 through 1959 is illustrated in Figure 1.

The attack rates of early infectious syphilis in New Jersey since 1955 are presented in Table 1.

TABLE 1.

PRIMARY AND SECONDARY SYPHILIS CASE RATES PER 100,000 POPULATION NEW JERSEY: 1956-1959

Year	Cases	Rate
1956	92	1.8
1957	114	2.2
1958	170	3.2
1959	301	5.6



It is apparent that the incidence of early syphilis is increasing and that the former firmly established downward trend has been reversed as indicated in Figure 2. A similar significant, though less marked change in national trend is revealed by Public Health Service data.[1] This reversal of trend has caused grave concern and has indicated a need for increased vigor in control activity.

Table 2 presents the age distribution of newly reported cases of early infectious syphilis.

TABLE 2.

PRIMARY AND SECONDARY SYPHILIS CASES BY AGE NEW JERSEY: 1959

Age Group	Number of Cases	Per Cent
All ages	301	100.0
Under 15	2	0.7
15-24	125	41.5
25-44	154	51.2
45 and over	20	6.6

Provisional counts for 1959 show that 42 per cent of the infectious syphilis reported in the state was among persons from fifteen to twenty-four years old.

TABLE 3.

PRIMARY AND SECONDARY SYPHILIS CASES BY SOURCE OF REPORT NEW JERSEY: 1959

Source of Report	Number of Cases	Per Cent
All sources	301	100.0
Private physicians	145	48.0
Clinics, hospitals and other institutions	156	52.0

It is interesting to note (Table 3) that forty-eight per cent of early infectious syphilis in New Jersey was reported by private physicians in 1959. From the inception of the national program, the private physicians of the state have contributed to successful venereal disease control.

1. Brown, W. J., Sellers, T. F., and Thomas, E. W.: Journal of the American Medical Association, 171:389 (Sept. 26, 1959).

Table 4 indicates the geographic distribution of cases of early infectious syphilis within the state.

TABLE 4.

PRIMARY AND SECONDARY SYPHILIS CASE RATES PER 100,000 POPULATION SELECTED CITIES OF NEW JERSEY: 1959

Area	July 1, 1959 Estimated Population	Cases	Rate
New Jersey	5,423,000	301	5.6
Selected cities	756,000	159	21.0
Elizabeth	123,000	15	12.2
Newark	483,000	124	25.7
Paterson	150,000	20	13.3

More than two-thirds of the infectious cases reported in 1959 were in the relatively densely populated Metropolitan State Health District, comprised of Bergen, Essex, Hudson, Passaic, and Union Counties. Three cities, with 14 per cent of the state's population, accounted for 53 per cent of the infectious syphilis cases in 1959.

Although New Jersey for several years enjoyed the obvious benefits of the decreasing incidence of syphilis, certain grim and costly reminders of the necessity of continued vigilance against new outbreaks remain. There have been fewer and fewer new admissions of patients with disability due to brain damage from syphilis to state and county hospitals; but in 1959 there were still nearly 600 persons with chronic brain syndromes due to syphilis in tax-supported hospitals in the state. The care of these patients costs over $1,000,000 a year. In view of the apparent resurgence of syphilis, the toll of disability among untreated cases, and the continuing high cost of maintenance of hospitalized late cases, it must be concluded that the dimensions of syphilis as a public health problem are but little diminished.

Moore [2] stated in 1951 that the most significant contribution of the United States to syphilis control was the widespread use of the epidemiologic method in casefinding. The basic epidemiologic principle of progression from a reported case of infectious syphilis to the discovery of additional cases among sexual contacts is the heart of venereal disease control. Contact investigation has been recognized for many years [3] as a valid and useful component of syphilis control programs. It is the basic infectious syphilis casefinding device in this country,[4] and, in New Jersey, it is the mainstay of the casefinding phases of the venereal disease control operation.

The elements of syphilis epidemiology as practiced in New Jersey include the activities of diagnosis, reporting, interviewing, investigation, re-interviewing, evaluation of interviewing and cluster testing.

Accurate, early diagnosis of syphilis in the primary or secondary stage is a prerequisite to all subsequent phases of epidemiology. Clinical examination, thorough serologic evaluation, and darkfield examination of genital or other suspicious lesions all are indicated when infectious syphilis appears a possibility.

Prompt reporting of all cases also is an essential component of the epidemiologic process. The State Sanitary Code† requires that every physician attending any person infected with syphilis report the case directly to the State Department of Health within twelve hours after diagnosis. To avoid initiation of unwarranted activity in connection with a non-infectious case, a report of primary or secondary syphilis routinely is confirmed orally with the reporting physician or clinic by a venereal disease epidemiologist.

Arrangements are made promptly with a reporting physician or clinic for every infectious syphilis patient to be interviewed for sex contact information. An interview is completely confidential and is conducted in conformance with high ethical and professional standards. The initial rough gauge of the success of interviewing is the "contact index," that is, the number of contacts obtained per patient interviewed. Trained interviewers have learned that during the time when infection is acquired or transmitted the average patient may experience sexual exposure to four or five con-

2. Moore, J. E.: Am. J. Syph., 35:119 (March 1951).

3. Wright, John J.: Journal of the American Medical Association, 147:1408 (Dec. 8, 1951).

4. Bauer, T. J.: Journal of the American Medical Association, 152:300 (May 23, 1953).

†Confidential Venereal Disease Report, Form VD-2, is provided to physicians by the State Department of Health for use in reporting diagnosed cases.

tacts. The well-known reluctance of patients to reveal contact information is usually not an insurmountable obstacle to a trained, experienced interviewer.

On completion of an interview, investigation to locate contacts is begun without delay. Contacts are referred for examination to their family physicians or to public clinics, as they may desire. Information concerning contacts living in other states is forwarded expeditiously. The privacy of sources of contact information is carefully protected during investigation, and the need for tactful, discreet approaches to contacts is observed. A properly performed investigation almost always results in the voluntary reporting of the contact for examination.

Infectious syphilis patients are re-interviewed routinely, often more than once. Re-interviewing is indicated urgently if a source infection is not found among the contacts originally named. The re-interview serves to secure additional contacts and supplementary information on unlocated contacts previously named. In the experience of State Department of Health venereal disease epidemiologists, re-interviews often are more productive than initial interviews.

The relative success of interviewing and the investigation stemming from it can be measured by certain indices:

Epidemiologic index: The ratio of the number of cases of syphilis (all stages) identified among syphilis contacts to the number of patients interviewed. An interview of an infected patient that does not result in identification of at least one infected contact is an epidemiologic failure.

Brought-to-treatment index: The ratio of the number of infected contacts brought to treatment for the first time to the number of patients interviewed.

Lesion-to-lesion index: The ratio of the number of cases having primary and secondary lesions found among contacts of patients with infectious syphilis to the number of infectious patients interviewed. Health Department interviewers throughout the country find approximately three primary-secondary lesion cases among contacts for each ten infectious patients interviewed.

Obviously, the closer the lesion-to-lesion ratio approaches one-to-one, the more successful are interviewing and investigation as epidemiologic devices.

Cluster testing is an extension of these epidemiologic functions to provide for serologic examination of associates of a patient and his contacts and other socially related persons. Cluster testing is an adaptation of standard procedures that takes into account the truly epidemic nature of syphilis and the limitations of contact investigation alone. This technic is used extensively in New Jersey and many other states, and substantially increases the epidemiologic yield. Cluster testing will be definitively discussed in a separate paper.

Contact investigation has been developed as a public health specialty, as it has been found that persons specially trained in interviewing and investigation perform most efficiently.[1]

Successful contact investigation is technically complex and time-consuming. Both time and skill are required for the careful interview of patients for contact information to locate contacts and to arrange for medical examination. These procedures are used throughout New Jersey in the follow-up of infectious syphilis cases diagnosed and treated in public clinics.

The services of contact investigation are constantly being extended in the follow-up of patients of private practitioners. This extension of service is a vital factor in syphilis control.

The Venereal Disease Control Program of the New Jersey State Department of Health has a staff of venereal disease epidemiologists whose primary responsibility is to respond immediately to requests from private physicians and clinics for assistance in syphilis epidemiology. If a physician does not request assistance, a venereal disease epidemiologist is assigned to communicate with the reporting physician and to offer epidemiologic services. Prior to meeting and interviewing a patient, his physician is consulted. In every case, due regard is given the patient's privacy, the doctor-patient relationship, and marital, employment, and social status. The epidemiologist works cooperatively in providing for effective

epidemiologic follow-up, representing both the physician and the public health agency. When investigations are completed a summary of epidemiologic findings is reported to the physician.

"Practical eradication" of syphilis in the United States is an announced goal of the Public Health Service.[5] In New Jersey, this is an attainable goal if public health agencies and all physicians, clinics and hospitals recognize the epidemic potential of every case of infectious syphilis and fully exploit the epidemiologic resources available.

5. Brown, W. J.: U. S. Public Health Service, Address at VD Control Seminar for Public Health Service in Baltimore (April 29, 1959).

State Department of Health

Criteria in Evaluating Depressions

Minor depressions can often be handled by the nonpsychiatric physicians who treat 75 per cent of depressives.

The diagnosis of a depression is made on the biologic and psychic manifestations. The patient may deny psychic manifestations reported by his family. The earliest complaints are insomnia, anorexia and decreased sexual desire. Constipation and menstrual dysfunction seem to be related to the more severe depressions.

The importance of the psychic manifestations lies in the evaluation of the depth of a depression. Other signs of use in diagnosis are slowness of movement, restlessness, posture and facial expression.

Suicide must be considered in any depression. Questioning the patient about suicide may help him to talk about it and may convince him that he can be helped. Frequent symptoms are expressions of hopelessness and feelings of worthlessness, inadequacy, loneliness and introversion. Expressions of guilt are often related to unconscious hostility toward others and may be introjected. Other important points are the basic personality, and whether he has serious physical disease, chronic disease or severe pain.

Popular misconceptions regarding suicide include the views that religious belief acts as a check and that those who talk about suicide, as well as children and mental defectives, never actually kill themselves.

If the depression is not severe, if none of the suicidal danger signs are present, and if there is no serious psychopathology, the patient's physician is often in a better position to help him than a strange figure—the psychiatrist—would be. The important factor in psychotherapy is to be a good listener and gain the patient's trust. The importance to the patient of the universalization of guilt feelings by the physician cannot be overemphasized. The depressive is glad to learn that everyone has neurotic traits, and that we differ only in the degree to which we manifest these traits. Patients often attach much anxiety or guilt to events or thoughts that may be a general normal development of the personality. The physician can survey family and home relationships objectively, and can take the responsibility for moves which the patient knows to be advisable but which make him feel guilty.

—Usdin, Gene: Journal of the Louisiana Medical Society, 111:262 (1959).

HERMAN LEVY, M.D.

Passaic

Third Degree Tears in Obstetrics*

A third degree tear often frightens the practitioner more than the patient. Dr. Levy here outlines a simple and deliberate plan for handling this condition.

THIRD degree tears in obstetrics are classed in three categories: (1) The external sphincter tear which extends into the most distal part of the rectal lumen. (2) The tear into the rectal lumen through its anterior wall a little higher up and (3) The tear high up in the rectal wall near the cervix. Of this last type I have seen only one and discovered it accidentally after having repaired an episiotomy and routinely inserted my finger into the rectum. I felt the distal end of the finger emerging in front of the cervix.

Generally one associates third degree tears with a large head or a small outlet or with too forceful an expulsion of the head. Not always is this true, however. To be sure, tensile strength of tissues of the pelvic floor, trauma from forceps or trauma from an after coming head and chin may indeed produce a third degree tear. And yet, the most recent such tear that I have had occurred in the delivery of a premature five-pound infant, three weeks before expected delivery date and without the use of forceps. In this case, an episiotomy had not been considered necessary. The delivery was simple, not precipitate, with no trauma of any kind. It was indeed surprising therefore when the finger introduced into the rectum came up into the vagina.

The most important thing in handling a third degree tear is to know that it is present. This calls for a thorough examination of the whole birth canal in every case post-partum. A finger should be inserted into the rectum and the tip tilted anteriorly in such a way as to make a thorough exploration under good light possible with good retraction and separation of labia and vaginal walls. I have sometimes inserted a yellow colored rectal bougie. The one we use is known as the Hudgin's bougie and has a wide diameter. If the bougie is seen through the vagina, a tear is present.

The only way positively to prevent it, would be by doing a deep episiotomy through the anterior rectal wall. I have heard of this procedure but I am loath to do it routinely.

TECHNIC OF REPAIR

ON realizing that a third degree tear has developed, inevitably the attending obstetrician or doctor feels a certain amount of mental anguish and resentment. He thinks of the sequels—a fistula, a series of operative but unsuccessful repairs, a delicate recto-vaginal partition remaining after surgery and so on. However, the physician here must remain calm and take a deliberate inventory of the problem. What is best to secure a good repair? How about anesthesia, assistance, light, instruments? No one should even try to do such a repair without

*Read by invitation October 12, 1959 before the Maternal Welfare Committee of the Passaic County Medical Society.

help. An experienced scrub nurse should be available, but this is not enough. She has enough to do threading needles, cutting sutures and providing sponges. She should not be taxed with the additional burden of being first assistant any more than you would want to tax the anesthetist with being first assistant. A competent first assistant, preferably a doctor who has assisted at obstetrical and gynecologic repairs, should be used. His contribution will help much to relieve the tension and burden of the operator.

The first step is to outline or delineate the boundaries of the tear by the use of small delicate Allis or Pennington or T clamps, crushing tissue as little as possible. After having the tear outlined, try, if feasible, to dissect away some of the tissue from the mucosa of the rectal lumen edge on each side so that the first row of sutures will take only mucosa plus a thin layer of supporting fibrosa. After doing this dissection with the finger in rectum and bayonet blade scalpel, one may change gloves. The finest suture Lukens intestinal, on an atraumatic needle should be used and the sutures should be interrupted and placed about an eighth of an inch or so apart, tying the knots not too tightly. The next row of sutures with the same material should also be interrupted and overlapping the first row and finally the third row overlapping the second row in the same manner. After that, consider the rectal repair completed and do whatever else is to be done, in the way of a general perineorrhaphy or episiotomy repair. It is perhaps advisable to put in a vaginal gauze pack somewhat to splint the wound additionally.

AFTER-CARE

AFTER-CARE is as important as the repair itself. A period of constipation enforced as long as possible is advisable. With peritoneal exudate sealing over a wound, repair on the part of nature is faster in the abdomen than it is low down on the perineum where there is no help from the peritoneum. Constipate the patient as long as possible, 7 to 12 days; and in my last case actually 2 weeks without distress. This is made possible by continuing a non-residue diet. By starting from scratch and giving only liquids for a day or two postpartum then adding a new item of food every day, Jello, cereal, toast, soft-boiled egg, mashed potato, it is possible to keep the patient happy with the expectation that each coming day will bring something additional into the diet. She should be bed confined and should be questioned about foods that "disagree" with her or give her loose stools. After the first six to ten days some form of opiate and belladonna is advisable to keep the lower bowel asleep. Together with this sulfanilamides and antibiotics are given during the healing period as well as Barraca-C® and B_{12} along with bed rest.

When the first bowel movement has approached mineral oil in a rather sizeable quantity is given the night before. Never permit an enema with a rubber tube. Indeed, at no time during the convalescence should a rectal tube be used. As a matter of fact it is wise not to allow an enema for a considerable time as no one knows how thin or thick a scar is present. A thin film-like scar could easily be penetrated by an enema nozzle.

THE EMOTIONAL COMPONENT

SUCH a prolonged period of constipation never does harm. The end justifies the means.

With all this fine and meticulous attention to detail there is still one unhappy circumstance to deal with and that is the emotional component. The typical obstetrical patient today considers herself "enlightened." In the course of conversation with other patients on a more liberal routine, she will decide that there is something "unusual" the matter with her. It is best to give her some explanation of what is going on. Be perfectly frank in all respects. If the result is good she will appreciate this frankness and be happy that she cooperated. If the result is not good she cannot say that the obstetrician was guilty of deception.

PROGNOSIS

THE outlook today is far happier than it was a few decades ago. If, however, the result is not good, a period of observation may be needed to see if the recto-vaginal fistula will close spontaneously during the months that follow. In this interval, it is better to keep the patient on a low roughage diet. Anything which will cause diarrhea must be avoided. She should be kept moderately constipated. If healing does not occur, secondary repair is then indicated.

158 Lexington Avenue

Congenital Megacolon

In infancy three types of Hirschprung's disease may be distinguished: neonatal; infantile; and retarded. In the *neonatal* type, severe symptoms are present from the onset, and the disease runs a rapid unfavorable course. In the severe *infantile* type, the symptoms develop in the first few months of life; about half of these babies die. In the *retarded* type the symptoms do not develop until after the first year.

The symptoms start with chronic constipation, followed by the passage of small hard stools alternating with diarrhea; then there is a progressive swelling of the abdomen, vomiting, and deterioration in general condition. Diagnosis depends on the x-ray picture. The gut is greatly distended with gas and fluid. In the rare cases where clinical and x-ray evidence does not clinch the diagnosis, a biopsy of the rectal or colonic wall should settle it, since the intramural plexuses are absent in Hirschprung's disease.

Medical treatment is useful only as a preparation for surgery. It may include repeated rectal dilation with sounds (though this is effective only when the affected segment is short) and the administration of neostigmine. Splanchnic infiltration and acetylcholine are useless; large enemas are dangerous.

In surgical treatment, the results of simple abdominal resection or rectosigmoidomyotomy are not satisfactory. Swenson's operation is dangerous in infants. In the operation recommended by Duhamel, an abdominal resection of the affected part of the bowel is followed by a retrorectal and transanal lowering of the colon. Seven consecutive cases were so treated with excellent results.

—Abstracted from an editorial in the Parisian *Concours Medical,* 81:3347 (August 1959).

Bowen's Disease & Systemic Cancer

Bowen has described a chronic solitary lesion composed of lenticular papules. The histologic picture of atypical epithelial proliferation also occurs in multiple, non-elevated, scaly or crusted plaques. Specimens for study were obtained from 35 patients after death and were compared with similar materials from 35 patients with senile keratosis, 35 with squamous-cell carcinoma of the skin, 139 with exfoliative dermatitis, and many with other cutaneous diseases. Average age of onset for the 35 patients with Bowen's disease was 54 years; duration of the lesion from onset to surgery ranged from 5 months to 30 years. The lesions varied in diameter from 0.7 to 13 centimeters with a median of 2 centimeters. They usually appeared as erythematous, pigmented, crusty, scaly fissured, keratotic plaques. Their configuration varied from round plaques, sharply demarcated from the surrounding tissue, to an irregular, polycyclic, lenticular pattern. They were firm, indurated, rough, and granular to palpation. The first lesion surgically removed was most frequently diagnosed as squamous-cell or basal-cell carcinoma. Only once was the diagnosis of Bowen's disease made at the first examination of a specimen. Surgical excision of the lesion is the recommended treatment; the need for sufficiently wide excision was indicated by the fact that in four patients the lesions were clearly invasive and in two others widespread metastases appeared. The evidence of an association of Bowen's disease with internal and cutaneous cancer was convincing, and it is suggested that the lesions are cutaneous manifestations of a systemic carcinogenic disease process.

—Graham, J. H. and Helwig, E. B.: Arch. Dermat., 80:133 (Aug.) 1959.

A. Marshall Smith, Jr., M.D.

New Brunswick

Thyroid Crisis*

Case Report and Review of Current Management

At the time this article was received, Dr. Smith was resident in medicine at the Presbyterian Hospital in Philadelphia. This paper won first prize in a contest by the Delaware Valley Chapter of the American Medical Writers' Association.

Prior to the introduction of anti-thyroid drugs, thyroid crises were common complications of hyperthyroidism. McArthur, *et al.*[1] found records of 36 cases of "storm" in 2,033 patients with hyperthyroidism admitted to the Massachusetts General Hospital in a 25-year period ending in 1947. Eleven were "medical storms" with 8 deaths (73 per cent), 25 "surgical storms" with 16 deaths (64 per cent). They defined thyroid storm as "a life-endangering augmentation of the symptoms of thyrotoxicosis in which the patient's response is out of proportion to the exciting stimulus, whatever its cause." Death was attributed in some instances to breakdown of the central nervous system; in others to cardiovascular collapse or to hepato-renal failure. Rives and Shepard,[2] reviewing 25 cases of thyroid crisis among 484 cases of thyrotoxicosis, listed three causes of death: inadequate pre-operative preparation; withdrawal of adequate therapy; and unknown factors. Other causes mentioned by various authors[1,3] include infections and emotional disturbances. Kelly and Bliss[4] reported a fatal thyroid storm which began spontaneously 6 months after cessation of propylthiouracil therapy. They advised frequent observation of patients after withdrawal of a thyroid-blocking drug. We have recently had a similar experience with storm occurring 9 months after administration of methimazole† was discontinued. We were somewhat handicapped in management of the patient because of the meagerness of recent information on this condition. It is the purpose of this paper to present our experience and to review briefly the present concepts of treatment of thyroid crisis.

CASE REPORT

A 49-year old housewife was first seen in the fall of 1955, presenting the classical signs and symptoms of hyperthyroidism. Her thyroid gland was slightly enlarged. Protein bound iodine was 10.1 mcg. per 100 ml. She was treated with methimazole,† 15 milligrams every 8 hours, and became asymptomatic within four weeks. Administration of methimazole† was continued until January, 1957, when it was stopped abruptly.

In May, 1957, she seemed generally well, but her physician noticed a fine tremor of her hands, and failure to gain weight despite an increased appetite. The 24-hour uptake of radioactive iodine was 43 per cent, top normal in the euthyroid range. Treatment with I^{131} was advised, but the patient failed to keep her appointment.

She was next seen in October, 1957, with obvious recurrence of hyperthyroidism, her symptoms including a 7 pound weight loss, heat intolerance, muscle weakness, and shortness of breath. I^{131} treatment was scheduled and the patient notified

*From the Department of Medicine, Hartford Hospital, Hartford, Connecticut.

†Tapazol®, Eli Lilly and Company, Indianapolis, Indiana.

1. McArthur, J. W., Rawson, R. W., Means, J. H. and Cope, O.: J.A.M.A., 134:868 (1947).

2. Rives, J. D. and Shepard, R. M.: Am. Surgeon, 17:406 (1951).

3. Ralli, E. P.: Clin. North America, 41:717 (1957).

4. Kelly, T. R. and Bliss, T. L.: Ann. Int. Med., 40:1223 (1954).

on the morning of October 30, 1957, that the supply had arrived. She commented at the time that she "felt fine," but the same afternoon she suddenly experienced weakness and "nervousness" and became excited. She had marked tachycardia and fever, and she was sent immediately to the hospital. There she appeared acutely ill and extremely "nervous." She seemed unable to talk above a whisper. Blood pressure was 168/60, pulse 60, respirations 22, and temperature 104.2. The thyroid gland was diffusely enlarged, with a palpable and auscultable bruit. No abnormal eye signs were noted. An electrocardiogram showed supraventricular tachycardia.

Initial therapy consisted of oxygen by tent, alcohol sponges, intravenous fluids with added vitamins, reserpine, sodium phenobarbital, chloramphenicol, and methimazole.† By the next morning her temperature was normal, but she had a heart rate of 160 with a grossly irregular rhythm. An electrocardiogram showed atrial flutter-fibrillation with occasional premature ventricular contractions and evidence of myocardial ischemia. Quinidine brought about rapid conversion to atrial flutter at a rate of 200 per minute, with a 2 to 1 atrioventricular block. Three days later the cardiac rhythm was normal, apart from an occasional premature ventricular contraction.

During this stage she was confused and hallucinatory. The hallucinations persisted to some extent throughout her hospital stay. Her management was further complicated by the development of a drug rash on the seventh hospital day, and neutropenia due to methimazole† on the twenty-first day and to propylthiouracil on the thirty-first day. She was finally given definitive treatment with I^{131} on December 6, 1957, and discharged on December 11, 1957. Report from her private physician 14 months later indicated that she was completely free of symptoms and enjoying full activity. Laboratory studies during hospitalization are shown in Table 1.

TABLE 1.
LABORATORY STUDIES

Date	WBC[1]	% Neutro	BMR	PBI	Chol	RAI	RAI Conversion 4	24	48	72
10-30-57	4,000	80								
31	5,500	52								
11- 1-57			58							
2				7.7		13.6[2]	.091	.087		.445
5					200					
6	6,000	56								
7				7.3						
8[3]			60	8.0	262	57.8	.202	.930	1.000	
12	5,600	47	31	8.0						
15			40							
20	5,000	29								
21[4]	4,900	26	22							
23	7,200	42								
25[5]	9,100	30								
26	7,330	35								
27	7,500	27								
28	7,800	32								
29	5,000	27								
30[6]	5,000	27								
12- 1-57	7,500	35								
2				8.6						
3	7,000	33		7.2		64				
4	7,400	66								
5	6,500	63								
7						60				
9	6,400	31								
10	7,000	30								

1. Key to Abbreviations:
   WBC—White blood cells per cubic millimeter
   Neutro—Neutrophilic leukocytes
   BMR—Basal metabolic rate (all figures given are "plus")
   PBI—Protein bound iodine in micrograms per 100 ml.
   Chol—Cholesterol in milligrams per 100 ml.
   RAI—24-hour radioactive iodine uptake by thyroid gland in per cent
   RAI Conversion—Ratio of protein bound iodine[131] to total iodine[131] measured in serum at 4, 24, 48, and 72 hours after administration of a measured dose of iodine[131]
2. Official Interpretation—"Hyperactive configuration. Block (low quantitatively) in uptake presumably due to methimazole."†
3. These studies were done after methimazole† had been withdrawn for a period of 24 hours. The RAI uptake and PBI[131]: Total I^{131} conversion ratio are definitely in the hyperthyroid range.
4. Methimazole† stopped permanently
5. Propylthiouracil started
6. Propylthiouracil stopped

COMMENT

BECAUSE of the present low incidence of thyroid crisis little space is devoted to this problem in standard medical textbooks. There has also been no recent review in the literature evaluating various methods of treatment. Many drugs may be used, each aimed at a different aspect of the problem. Thus each case must rapidly but critically be evaluated, and therapy directed toward the predominant disorder. The various forms of treatment as they apply to the several patho-physiologic disturbances will be discussed and tabulated (Table 2).

(1) *Excessive Circulating Thyroid Hormone*: Whatever the form of thyroid crisis, the basic problem is one of excessive circulating thyroid hormone. In the surgical patient, after the thyroid gland has been removed, the only task is support of the patient during the time required to metabolize the excess hormone already in the blood. Anti-thyroid drugs are of no value under these circumstances. In a "medical" crisis, however, the gland remains hyperactive and will continue to release thyroid hormone into the circulation unless specific therapy is given. Thus these patients should be given both an anti-thyroid drug such as propylthiouracil or methimazole,† and an iodide. The anti-thyroid drug should be given first, since iodides tend to block its action. The usual doses are: propylthiouracil, 100 milligrams every 6 hours, or methimazole,† 15 milligrams every 6 hours. One hour after the first dose of anti-thyroid drug the patient should be given sodium iodide, 300 milliliters of a 10 per cent solution intravenously, repeated every 6 hours. In extremely severe cases or in debilitated patients larger doses of propylthiouracil, even reaching 1 Gram per day, can be used without a significant increase in side reactions.[5]

(2) *Increased Liberation of Energy*: The cellular response to excessive thyroid hormone is an increase in metabolism, with utilization of oxygen and carbohydrate, and production of heat. Thus treatment should be aimed at meeting the increased body needs, at the same time lowering the metabolic rate. Oxygen should be administered, preferably by tent, since this will also aid in cooling the body. The patient should be given a high carbohydrate diet, intravenously if necessary, with an adequate vitamin supplement. If this phase

5. Bartels, E. C. and Kohn, M. M.: J. Clin. Endocrinol., 14:1403 (1954).

TABLE 2.

SUMMARY OF MANAGEMENT OF THYROID CRISIS

Pathophysiologic Disturbance	Treatment
1. Excessive circulating hormone	1. (a) Propylthiouracil, 100 mg every 6 hours, or methimazole†, 15 mg. every 6 hours. (b) Sodium iodide, 300 ml. or 10% solution I.V. every 6 hours (start one hour after (a)).
2. Increased liberation of energy	2. (a) Oxygen by tent. (b) High carbohydrate intake, by I.V. if necessary. (c) Vitamin supplement. (d) Alcohol sponges. (e) Chlorpromazine, 50 mg. I.M. every 8 hours. (f) Reserpine, 5 mg. I.M. stat, then 2.5 mg. I.M. every 4 to 6 hours.
3. Stress reaction	3. (a) Hydrocortisone, 100 mg. I. V. stat, then 50 to 100 mg. I.M. every 6 hours. (b) Antibiotics as indicated.
4. Cardiac abnormalities	4. (a) Digitalization for congestive failure (large doses needed). (b) Quinidine for arrhythmias.
5. Increased insulin requirements	5. Insulin as indicated.
6. Emotional upsets	6. (a) Sedation with barbiturates. (b) Meprobamate, 400 mg. four times daily during recovery phase

of treatment is neglected, severe liver glycogen depletion will result and lead eventually to liver failure.

The increase in body heat which accompanies the excessive metabolic rate can be overcome in two ways. The first is by external cooling with alcohol sponges and by adjusting the oxygen tent to the lowest possible temperature. The second means of lowering body temperature is "artificial hibernation" through the use of chlorpromazine. Although chlorpromazine is potentially a hepatic toxin, danger from this is apparently negligible in thyroid crisis. Weaver, Jones, and Smith [6] noted only a slight rise in serum bilirubin in one of their two cases. They believed that chlorpromazine acts by minimizing shivering and by peripheral vasodilatation. The dose of chlorpromazine recommended is 50 milligrams intramuscularly every eight hours.[7]

Some feel that reserpine, when used in thyrotoxicosis, exerts its main effect against the increased metabolism. DeFelice, Smith and Dearborn,[8] in animal studies, found that reserpine antagonized the effect of thyroid hormone on oxygen consumption. Thus reserpine in thyroid crisis should be of help in counteracting the effect of the excessive circulating hormone. Canary, *et al.*[9] used reserpine in 20 patients with thyrotoxicosis, including one with post-operative crisis. They reported good results, and concluded that the action is not central, but possibly related to adrenal steroid output. They recommended 5 milligrams of reserpine intramuscularly initially, followed by 2.5 milligrams intramuscularly every 4 to 6 hours.

3. *Stress Reaction*: Szilagyi, McGraw, and Smyth[10] suggested that thyroid crisis might be due to an impaired balance between the stress of excess thyroxin and the anti-stress defense of the pituitary-adrenal axis. During a thyroid crisis the body is undergoing severe stress which may result in adrenal cortical exhaustion and consequent collapse. Thus, ACTH and/or adrenal corticosteroids should be given in most cases. In the critically ill patient the use of these agents may be life-saving. Although Szilagyi, *et al.*[10] used ACTH with good results, Weir [11] believed that the adrenals would be unable to respond and advised administration of hydrocortisone intravenously in the dose of 100 milligrams, repeated as indicated or followed by 50 to 100 milligrams intramuscularly every 6 hours.

Under stress reactions it would be well to consider the precipitating cause of the thyroid crisis, if known. For example, if the crisis were preceded by infection, an appropriate antibiotic should be given. In the case of post-operative storm prevention, by means of adequate pre-operative anti-thyroid preparation, is the best treatment.

(4) *Cardiac Abnormalities*: The most common cardiac complication of thyroid crisis is tachycardia, unresponsive to any form of therapy until the liberation of excessive energy and body heat is controlled. If congestive failure develops, digitalization should be tried, although much larger doses will be required than in the average patient whose failure is on a purely cardiac basis.[3] For arrhythmias, such as atrial fibrillation and premature ventricular contractions, quinidine is the drug of choice.[12] Full therapeutic effect should be achieved as rapidly as possible.

(5) *Increased Insulin Requirements*: The increased metabolic rate in hyperthyroidism results in an increased insulin requirement. The incidence of diabetes mellitus among hyperthyroid patients has been estimated at 1 to 3 per cent. Hanscom and Ryan [13] recently reported a case of combined thyroid crisis and diabetic acidosis. Every patient with thyroid crisis should be evaluated carefully for associated diabetes mellitus and insulin given as needed. The "pre-diabetic" patient may require insulin during a thyroid crisis, but should re-

6. Weaver, J. A., Jones, A. and Smith, R. A.: British M. J., 1:20 (1956).
7. Hunter, A. R.: Lancet, 269:173 (1955).
8. DeFelice, E. A., Smith, T. C. and Dearborn, E. H.: Proc. Soc. Exper. Biol. & Med., 94:171 (1957).
9. Canary, J. J., Schaaf, M., Duffy, B. J. and Kyle, L. H.: New England J. Med., 257:435 (1957).
10. Szilagyi, D. E., McGraw, A. B. and Smyth, N. P. D.: Ann. Surg., 136:555 (1952).
11. Weir, R.: Personal Communication.
12. Morgan, F. M. and Corsiglia, V. F.: U. S. Armed Forces M. J., 9:571 (1958).
13. Hanscom, D. H. and Ryan, R. J.: New England J. Med., 257:697 (1937).

turn to normal once the thyroid disease is controlled.[13]

(6) *Emotional Disturbances*: Emotional upsets may precipitate a thyroid crisis. Severe mental derangements may develop during and after the crisis, as noted in our patient by hallucinations. During the peak of the hypermetabolic episode, the patient may be extremely agitated, requiring sedation, preferably with one of the shorter-acting barbiturates. Tranquilizers, such as meprobamate, have been recommended but are probably of more value once the crisis has been controlled and the patient is receiving definitive treatment.[14]

SUMMARY

A CASE of thyroid crisis occurring 9 months after withdrawal of methimazole† therapy has been presented, and rational therapy for the control of a thyroid crisis has been outlined.

The effective management of thyroid crisis depends upon an understanding of the multiple pathophysiologic disturbances present or predominant in the given patient, and of the rationale of therapy aimed at each specific disturbance.

14. Yohalem, S. B.: New York J. Med., 57:2518 (1957).

I thank Dr. Edward Nichols of Hartford, Connecticut, for the privilege of presenting the data on his private patient.

274 Livingston Avenue

How Safe is Oral Polio Vaccine?

The risks of oral polio vaccine "appear to be greater than had been suspected" and much more knowledge must be obtained before it can be considered safe, three Baylor University researchers said in the October 31 (1959) issue of the A.M.A. *Journal.*

Vaccines made from live polio viruses reduced in strength are now being given by mouth to thousands of children all over the world.

The researchers, Joseph L. Melnick, Ph.D., Matilda Benyesh-Melnick, M.D., and James C. Brennan, M.D., said, "if caution was called for in 1954 when Salk vaccine was introduced into field use, then caution should also be the watchword now."

Safety tests performed in a number of different laboratories are in "serious disagreement" about the degree of attenuation (reduction in strength) of the viruses, the authors said.

"We do not imply," they continued, "that such virus strains are dangerous either for the child or for the community; but the risks appear to be greater than had been suspected. More knowledge must be obtained . . . before the available attenuated strains can meet the criteria of a safe and effective vaccine . . ."

A study among Mexican children showed many who were free of polio antibody, but who failed to develop antibodies when given the vaccine. This apparently occurred because they were already infected with a nonpolio enterovirus. This infection blocked the implantation of the polio.

Such interference might limit the effectiveness of an orally given vaccine in areas where enterovirus infections are common.

Giving vaccine to children whose contacts are chiefly immune by natural infections tells very little about the safety of a vaccine for a community, since the opportunities of spread in an immune population are severely limited, they said.

Thus the vaccine must be tried in groups with low rates of immunity. Then it can be determined if a spread of the virus to nonvaccinated individuals is dangerous.

The question of safety resolves itself on the frequency of disease in vaccinated children and their contacts, as compared with that anticipated from natural infection, they concluded.

S. A. Goldberg, M.D., Ph.D.

Newark

Melanomas

Sixth of a series prepared by the 1959 Cancer Control Committee of The Medical Society of New Jersey.

Moles are extremely variable. Melanomas may arise in a variety of cells that secrete melanin. While they may develop in any pigmented mole, they most commonly originate from a junctional nevus in the skin. They may also arise from the stellate cells of the meninges, the pigmented hexagonal cells of the retina and the pigmented cells of the rectum. Very rarely do they become malignant before puberty.

These pigmented tumors are often incorrectly diagnosed. When removing even the most innocently appearing mole, the doctor should have it sectioned and examined by a competent pathologist.

In some cases the original tumor is pigmented while the metastases are nonpigmented. In other cases the primary tumor is amelanotic while the secondary growths are highly pigmented. Pigmented nevi and melanomas occur relatively more frequently in blonde individuals or those who freckle easily and do not tan well on exposure to sunlight.

Pigmented nevi are not commonly found on the feet and genitals but the proportion of melanomas in these locations is relatively high. In other parts of the body they occur with equal frequencies. The feet and genitalia are more subject to repeated irritation hence tumors in these areas are more likely to undergo malignant change than the same tumors in other parts of the body.

The influence of hormonal stimulation is evidenced by the fact that nevi are invisible at birth and then show pigment after birth on exposure to light. Many are not visible until after the onset of puberty. At this time, pigmented nevi become more numerous, more darkly pigmented, and tend to become elevated. Some nevi in infants and children even if they show malignant characteristics histologically, may not behave as such until after puberty. This class of tumor should be called a prepubertal melanoma.

The malignant melanoma in its derivation from the pigmented nevus is closely related to the endocrine system and markedly influenced by the activity of the endocrines, notably the gonads, the suprarenal cortex and perhaps the pars intermedia of the pituitary body. Malignant melanomas often occur in adolescent girls and boys just after the onset of puberty when the tumor grows rapidly and becomes widely disseminated. A malignant melanoma developing from a pigmented nevus during pregnancy grows very rapidly and so widely disseminates that it becomes inoperable.

It does not seem possible that a single injury to normal skin can induce a growth as highly complicated as a neuronevus or a malignant melanoma. Repeated chronic irritation of pre-existing moles could be a factor in changing them from benign to malignant. This is particularly true when moles are found on regions subjected to frequent and constant pressure, such as on the neck, the arms, the

groin, the feet, and the genitals. When a pigmented mole that has long been quiescent becomes elevated, shows increased pigmentation or ulceration or develops bleeding, and localized discomfort or pain, this may indicate that the tumor is becoming malignant.

TREATMENT

It has been said, incorrectly, that a pigmented mole should not be removed unless it bothers the individual. This is a dangerous doctrine. When a pigmented mole begins to "bother" the patient, a melanoma may have already developed. The physician may excise what he believes to be a benign mole in a conservative fashion in the office without a microscopic study of the specimen only to have the patient later return with evidence of regional or distal metastases. *When a pigmented mole is removed during its benign state it never recurs.* Local recurrences or distant metastases after removal indicae that the original tumor was malignant at the time of excision. These tumors are so radio-resistant that x-ray or radium therapy is contraindicated. Electrodesiccation is too superficial and not wide enough to remove all the neval cells. If a part of the tumor remains, the irritation of this procedure may induce it to grow more rapidly and even to metastasize. Wide surgical excision is the only means to combat this neoplasm. In the Memorial Hospital the ratio of "five year survival" for malignant melanoma without metastases was 18 per cent. With metastases, and treated by radical surgery the survival rate was 15 per cent.

27 South Ninth Street

Radioactivity in Food

Radioactivity in food now presents no dangers, but research must continue as the peacetime use of nuclear energy increases, a Cornell University researcher wrote in the October 31 (1959) *Journal* of the A.M.A.

Dr. C. L. Comar, author of the report, pointed out that environmental contamination today is due largely to "fall-out" from nuclear weapons. Eventually this contamination may be increased by such peacetime activities as mining of uranium and thorium ore and fuel processing; reactor installations in power plants, submarines, ships and aircraft, and radioisotopic applications in medicine, industry and agriculture.

The relative hazard of radioactive material is governed by several factors. These include the amount released into the enviroment; the length of time the radioactivity lasts in certain materials; efficiency of transfer through the food chain to the human diet; the degree of absorption by the body, and the length of time the material is retained in the body.

The radioisotopes from fall-out which are of the greatest concern are iodine, barium, strontium and cesium. Those of iodine and barium are short-lived, while those of strontium and cesium retain their radioactivity for a long time.

Radioactive contaminants are transferred to man by specific pathways through the food chains, Dr. Comar said. For instance, barium-140 goes from the atmosphere to vegetation, to cattle, to milk, to man.

The present contamination of diets originates mainly from surface contamination rather than from the soil reservoir.

This soil reservoir will be an increasingly important source of contamination, even if nuclear tests are stopped. The present contamination will spread into the ground and persist there. This is especially true of strontium and cesium, which retain radioactivity for long periods.

Thus close checking of dietary levels of radioisotopes and research to understand their possible effects on man must be continued indefinitely, Dr. Comar concluded.

Arthur Winter, M.D

George Ross, B.S

East Orange

The "Dip-Stick" in the Estimation of Cerebrospinal Fluid Protein*

A rapid do-it-yourself method of estimating spinal fluid protein is described in this useful little monograph by Dr. Winter and Mr. Ross.

Data are presented here which indicate that a commercially available "dip-stick" is useful in estimating cerebrospinal fluid protein. The one we used is known as Uristix® (Ames Company, Elkhart, Ind.). It is a short strip of bibulous cellulose impregnated with reagents to detect and estimate glucose and protein in the urine. The yellow protein test area at the tip of the strip is impregnated with a mixture of tetrabromphenol blue in a citrate buffer at a pH of about 3.0. In the absence of protein, the indicator has a yellow color at this pH. In the presence of increasing concentrations of protein the indicator will change from a green to blue color. The protein test area is separated from the red glucose test area by a water resistant barrier. The glucose test was found unsatisfactory for the estimation of spinal fluid sugar and was not used. A color chart is supplied with the Uristix® which, in the case of protein, has standardized colors corresponding to the following concentrations in milligrams per 100 milliliters: 0, 30, 100, 300, and 1,000.

The spinal fluid protein was estimated by dipping the Uristix® momentarily into the spinal fluid and, after 10 seconds, comparing its color with those of the chart. The concentration equivalent of the color on the chart most closely corresponding to that of the stick was taken as a result. In some instances, effort was made to estimate concentrations between those given on the chart. This procedure was followed with 55 specimens of spinal fluid by the authors, working independently; and their results were compared with each other as well as with those obtained by a quantitative sulfosalicylic acid-turbidimetric method,[1] subsequently carried out. An examination of these results reveals that the agreement of the two observers with each other is excellent and that the agreement with the quantitative method is fairly good. The sticks failed in seven cases where a normal concentration (30 milligrams) was found with the Uristix® and increased amounts (55 to 65 milligrams) with the quantitative method. In each case in which such discrepancies occurred, the tests were repeated with good duplication of the original results. The reason for the error in these cases is not clear. We suggest that the method could be much improved if a stick could be developed specially for the estimation of spinal fluid protein with colors corresponding to the following concentrations in milligrams per 100 milliliters: 0, 25, 50,

*From the Neurosugery and Laboratory Divisions, Montefiore Hospital, New York.

1. Denis, W. and Ayer, B.: Archives of Internal Medicine, 26:436 (1920).

75, 100, and 200. This suggestion has been made to the manufacturers.

SUMMARY AND CONCLUSIONS

A METHOD has been described [2] which makes it possible to estimate spinal fluid total protein with reasonable accuracy using a commercially available "dip-stick." The method has several important advantages. It permits the estimation of protein with a very small sample. In instances in which it is dangerous to withdraw an adequate amount, this is of great help. It may be used at the bedside supplying an immediate result which often is of prime consideration. In the laboratory it is likewise of assistance since it may be used to screen the fluids and thus indicate the correct aliquot to take for analysis. This saves both time and, more important, fluid which may be needed for other examinations.

2. Free, A. H. and Fonner, D. E.: Abstract of 133rd Meeting of the American Chemical Society, published by the Society in April 1958; pages 14c-15c.

377 South Harrison Street

Giant Stomach Ulcer

It is generally believed that the larger a peptic ulcer, the greater the likelihood of carcinomatous change. Isidore Cohn *et al.* report on an investigation of this, writing in the American Journal of GastroEnterology, 32:121 (Aug. 1959). They studied 48 gastric ulcers of more than 25-millimeter diameter.

Of the 48 cases reviewed, 40 were benign. The age distribution was that expected in cases of chronic gastric ulcer. The highest incidence was between 50 and 59 years, though large ulcers were found in young as well as old people. The predominance of males was in agreement with other series. In all cases symptoms had existed for at least a year, in a third of the cases longer than five years. The symptoms were no different than in the usual run of ulcers.

From the x-ray picture, a benign lesion was often diagnosed as malignant; 30 per cent of the diagnoses were accurate. In some cases the ulcer was not seen in the x-rays; by gastroscopy only one out of five was actually seen. The clinicians made the correct diagnosis in a third of benign cases.

Of 8 cases of cancer, 3 were classed as benign, in 3 no consistent diagnosis was made, and 2 were correctly diagnosed.

The operating surgeon diagnosed cancer in 23 cases of benign lesions and 4 cases of cancer; as a result the operative approach was radical in over half the cases.

Postoperative complications were absent in 36 cases and more or less severe in the remaining 12, 4 of which were fatal. These 4 patients had been admitted with major complications (perforation or massive bleeding).

Of 44 patients discharged from hospital, 27 have remained symptom-free. The frequency of multiple gastrointestinal lesions was striking. In 11 cases massive bleeding was the indication for primary treatment, while in 6 cases perforation necessitated immediate surgery.

No characteristic clinical picture of large gastric ulcers has evolved from this study but one conclusion has been drawn—that in large gastric ulcers a 33 per cent incidence of cancer can be expected. In 553 cases collected from different clinics in the U.S.A., Great Britain and the European continent the cancer rate is also 33 per cent.

The cases reviewed showed that the medical treatment of giant gastric ulcers is usually ineffective. To distinguish a benign giant ulcer from a malignant one, even by the most careful evaluation, is usually impossible. The liability of the giant ulcer to massive bleeding, perforation and pyloric obstruction is a further indication for early surgery.

Harry Halprin, M.D.

Montclair

Hyperglycemic Reaction to a Hydrochlorothiazide

For this first time in history, there is here reported a rapid rise in blood sugar following administration of a hydrochlorothiazide. Dr. Halprin alerts practitioners to this possible complication.

One of the modern hydrochlorothiazides, Esidrix® (Ciba) is a potent oral diuretic.[1] It is indeed, as effective as the parenterally administered mercurial diuretics. Esidrix® is given orally in a dosage range of from 25 to 200 milligrams a day. The usual daily dose is 75 to 100 milligrams. According to animal studies[2] it is less toxic than chlorothiazide, and is an exceptionally safe drug. Side effects are infrequent and rarely severe. Most untoward effects are overcome by adjusting the electrolyte balance, lowering the dose or giving the drug after meals. The electrolyte balance can usually be adjusted through dietary supplements.

This is the report of a 74-year old non-diabetic who had had signs of multiple myocardial infarctions since 1947. He had signs and symptoms of chronic decompensation. In December 1958 he was given Esidrix® as described below. At times his blood sugar reached 412 per cent. He was placed on a diabetic diet and given tolbutamide.* The hydrochlorothiazide was discontinued and the blood sugar dropped. Later he returned to the hospital and the Esidrix® was given again. And once again his blood sugar went up—this time to 185 milligrams per cent. At this level the hydrochlorothiazide was discontinued and chlorothiazide† was administered. The chlorothiazide† did not have the hyperglycemic effect.

The patient (a 74-year old retired engineer who had never had diabetes) was first admitted to the Mountainside Hospital (Montclair, N.J.) in 1957 for an acute antero-septal infarction.

He was treated and discharged under anti-coagulant and digitalis therapy. He continued to feel fairly well except for bouts of 1 or 2 plus pretibial and ankle edema and a 3 pound weight increase, until December 1958. During this time he was receiving an injection of Mercuhydrin® every 2 or 3 weeks.

On December 9, 1958 he was started on Esidrix® 25 milligrams twice a day. This dose was increased to 25 milligrams three times a day on December 23. It was continued this way for six days. On December 29 he complained of polyurea, polydypsia, loss of weight, weakness of the extremities and muscle cramps of 2 to 3 days' duration. We were suspicious of a low sodium syndrome, and he was hospitalized for studies of his serum electrolytes and chemistry. It was found that his blood sugar was 410 milligrams per cent and he had a 4 plus glycosuria for which he was treated with tolbutamide* 1.5 Grams a day and a diabetic diet of 1200 calories. The blood sugar was 410 on January 3, 1959. It was 210 a month later and 118 on February 20. On April 4, 1959, however, it was 185. On June 3, 1959, the blood sugar was 68 milligrams per cent. The April 4 figure (of 185 milligrams) followed four days of giving Esidrix® at 75 milligrams a day. The other blood figures on January 3 were: 29 blood urea nitrogen; 29 carbon dioxide; 87½ chlorides; 4 potassium and 134 sodium. Subsequent blood chemistries showed little change from this pattern.

*Under its Upjohn tradename of Orinase®.

†Under its Merck Sharp and Dohme tradename of Diuril®.

1. Wlodzimierz, Januszewicz, *et al.*: New England Journal of Medicine, 264:269 (August) 1959.

2. deHaven, Paul: Medical Science, 46:123 (July 1959).

The patient was readmitted on March 7, 1959 in myocardial failure with pretibial and 2 plus ankle edema and signs of fluid in the right chest. He was given antibiotics for several days (because of cough and low grade fever) redigitalized and this time treated with Mercuhydrin® as indicated.

March 27, three liters of a straw colored pleural fluid were removed from his right chest. While he was in the hospital under observation, we decided to re-evaluate the Esidrix® effect on his blood sugar. Because he had pretibial and ankle edema (and the liver was down 2 fingers) he was started on Esidrix® on March 27. He was given 25 milligrams three times a day plus a maintenance dose of digitalis (.1 milligram digitoxin daily). After six days on this medication, the signs of failure gradually cleared but his blood sugar rose once again to 185 without glycosuria. The Esidrix® was then stopped and he was treated with Mercuhydrin® every 7 to 10 days as needed. When he left the hospital on June 3, 1959, his blood sugar was 68 milligrams per cent. Nine days later, he was readmitted because of an attack of mild left ventricular failure when he was again redigitalized, given Mercuhydrin®, oxygen and finally placed on a maintenance dose of digitoxin 0.1 milligram per day and chlorothiazide† one Gram a day which he is still taking at the present time. He is feeling well and his blood sugar remains at a normal level, 72 to 97 milligrams per cent.

No matter how carefully experimental work with a new drug may have been carried out, it is only the prolonged use by the medical profession at large that will establish both the therapeutic efficacy and the safety of a compound.

Chlorothiazide (Diuril®—Merck Sharp & Dohme) was first subjected to clinical evaluation two and one-half years ago. About one year has passed since its closely related compound, Hydrochlorothiazide (Hydro-Diuril®—Merck Sharp & Dohme and Esidrix®—Ciba) had its first use in man. These were the first compounds in which a diuretic or saluretic effect was combined with a hypotensive action. They are effective when taken by mouth.

Gibson[3] recently reported that the side effects that were observed are mainly three categories:

1. Gastrointestinal intolerance in the form of nausea, cramps, and diarrhea. Though not uncommon, has rarely necessitated discontinuance of treatment.

2. Hypokalemia is the most common electrolyte imbalance. Hyponatremia and hypochloremia have been less common and disturbance of acid-base balance has been rare.

3. Skin rashes have been the most frequent evidence of allergic sensitivity but have occurred in less than 3 per cent in cases reviewed.

4. Blood dyscrasias have been reported only very rarely.

5. No mention is made of complication causing a disturbance of metabolism with a rise in carbohydrate, blood sugar and consequent glycosuria.

This unusual hyperglycemic complication in a nondiabetic patient who suffers primarily from coronary heart disease when treated with Esidrix® may or may not have been initiated by the hydrochlorothiazide. Certain special circumstances in this elderly man could have been the agent to disturb the normal carbohydrate metabolism. His repeated and persistent bouts of myocardial failure, liver congestion caused by myocardial decompensation, or some enzyme insufficiency as well as the hypochloremic alkalosis—all, or any of these factors may have been primarily responsible for the disturbed metabolism. Yet, the finger of suspicion seems to point to the hydrochlorothiazide. This deserves further study.

The literature thus far has no recorded similar case. It is for this reason that we wish to alert physicians who prescribe this powerful diuretic agent to be suspicious of the polyurea initiated during therapy with hydrochlorothiazides, especially when accompanied by signs and symptoms suggestive of a low salt syndrome. This may be a good time to examine the blood sugar values as well as the electrolytes.

3. Gibson, Augustus: Director of the Medical Research Division of Merck Sharp and Dohme at the March 1959 sessions of the American Therapeutic Society in a "Report on Hydrochlorothiazide."

4. Goldner, Morton: Jewish Hospital for Chronic Disease of Brooklyn, N. Y. Personal Communication to author.

145 Union Street

Leonard Tushnet, M.D.

Irvington

Impotence and Diabetes Mellitus

With current interest in psychosomatics, it is easy to forget the "somatic" part of this phrase. Dr. Tushnet properly reminds us not to be too enchanted by the emotional component of such illness.

Diagnostic acumen need not be confined to the mythical professor of a bygone age who smelled typhoid on entering a room. Like Claude Bernard's "prepared mind," it should be part of the daily practice of a physician. Not only does it give him great self-satisfaction, but it also often saves the patient much time and money in the treatment of his complaints.

The so-called "functional" disorders are the best areas in which such keen diagnostic sense may be displayed. In these days of emphasis on the psychic side of psychosomatic medicine it is necessary to remember that "psychologic problems" may arise from the soma. In this category fall the emotional depressions often seen early in carcinoma of the pancreas, enuresis in urinary tract anomalies, and impotence in diabetes mellitus.

The incidence of the last named has been described recently by Rubin and Babbott*. I have selected five cases from a general family practice to illustrate the need to search (and not very deeply) for other than emotional causes in a symptom complex characterized by shame, silence, and sexual fears.

CASE ONE

A married machinist, aged 38, frightened by sudden onset of impotence, sought advice. His physician took a thorough social and personal history. His wife, for a long time, had been refusing coitus because of fear of pregnancy following the difficult delivery of a 9 pound baby. He had had extramarital coitus with prostitutes but soon discontinued this for fear of venereal disease. He had lost ten pounds in the past six months; his weight was now stationary. On attempting coitus with his wife on several occasions recently, he had had poor erections and finally impotence, although libido was strong. His impotence was attributed by his physician to a guilt reaction and he was referred for psychotherapy.

There was no improvement in the impotence after six months of therapy. He did, however, develop an enormous appetite that was felt by his physician to be a substitution reaction.

His brother, four years his senior, was found to have diabetes mellitus. The patient discovered sugar in his urine in a family self-testing program. The diagnosis of diabetes mellitus was confirmed, treatment instituted, and psychotherapy stopped. Erections returned and normal coitus was possible after eight months of insulin and diet.

CASE TWO

A bookkeeper, aged 42, had had a normal marital sexual life until the death of his wife two years previously after a long illness. Since that time he had not attempted coitus, although he said he had strong "sex urges." He re-married and found to his chagrin that erections were poor and he soon became totally impotent. He attributed his impotence to "a guilty feeling" as well as the crowded sleeping arrangements at home, there being two children of each spouse by their previous marriages. Two of his brothers, his father and a sister were diabetics. Although there were none of the common symptoms of diabetes, glycosuria was present in a casual specimen; diabetes mellitus was subsequently diagnosed, and treatment started. After seven months, potency was normal.

*Rubin, Alan and Babbott, David: Journal of the American Medical Association, 168:498 (October 4, 1958).

CASE THREE

A teacher, aged 44, had polydipsia and weight loss for the past year. Two years previously, he had started psychoanalytic therapy on the advice of his wife's gynecologist, because of the onset of impotence. Before that time, sexual habits had been normal. He was the father of four children, all of whose birth weights had been over 8 pounds. His wife was his first cousin. There was a history of diabetes in the family. Glycosuria had not been present at the time of an insurance examination four months previously. Diabetes mellitus was diagnosed after urine and blood tests. Treatment was started, with rapid improvement in all symptoms, except the impotence. After six months, despite adequate diabetic control and the continuance of his analysis, there was no change in his condition.

CASE FOUR

An electrical worker, aged 32, became impotent after twelve years of marriage. Impotence coincided with the onset of vague weakness, thirst, bulimia, and weight loss. He was treated by a chiropractor and then by a "psychologist" of unknown qualifications. The latter told the patient that the appetite was an oral substitute for coitus and an unconscious response to his guilt feeling about cunnilingus. At the time of his treatment for a rectal abscess, diabetes mellitus was discovered and treatment started. Impotence disappeared after four months of good diabetic control.

CASE FIVE

A socially prominent broker, aged 39, complained of increasing weakness and fatigability. In the course of the history taking he added recent impotence to the list of symptoms. Glycosuria was found and diabetes mellitus subsequently diagnosed. After six months of treatment, his potency returned. He then reported that for about a year previous to the discovery of the diabetes he had been impotent. Ashamed to see a local doctor about his condition, he had been to three out-of-town psychiatrists. He had had several interviews with each and had a course of injections to improve his sexual ability from a physician in another city.

These cases illustrate the need for the family physician to bear in mind the most trivial remarks of the patient, the seemingly insignificant details of history (for example, in two of the above cases, the large birth weight of the progeny), and the necessity to guard against accepting the patient's psychologic explanation of his complaints without confirmation by the physician's own examination.

662 Eighteenth Avenue

Obstructive Cholangitis

Acute obstructive cholangitis is caused by accumulation of purulent material under pressure in the common bile duct. It may be secondary to stones, strictures, neoplasms, pancreatitis or parasites. The usual cause is biliary calculi. Response to conservative management with massive antibiotic treatment is poor.

In the authors' experience,* the only effective management, even in an extremely moribund patient, is decompression of the common bile duct. The manifestations of toxic shock disappear rapidly and *recovery promptly ensues*. Failure to operate will prove fatal.

The well-known clinical triad of chills and fever, jaundice and right upper quadrant tenderness or pain is accompanied by lethargy, confusion and shock.

*Reynolds, B. M. and Dargan, E. L.: Annals of Surgery, 150:299 (Feb. 1959).

Transposition of the Spleen

In 3 patients with portal hypertension complicated by esophageal varices, the spleen was transposed into the thoracic cavity. This surgical treatment was described by Turunen and Laitinen of Helsinki (Ann. Surg., 149:443, 1959). Severe hemorrhages from the varices ceased, and the varices decreased in size.

Splenoportography five years after operation revealed collateral circulation between the transposed spleen and the superior vena cava. The abundance of collateral vessels was in direct proportion to the pre-operative severity of the varices. The spleen was found to have shrunk. No symptoms of splenomegaly have since occurred.

Transposition of the spleen is a relatively safe procedure that may be done in patients in poor condition. Not shunting the entire portal circulation past the liver was thought to be of benefit.

J. Gerendasy, M.D.

Jersey City

Place of the Proctologist on the Maternity Service

The birth canal is so closely related—anatomically, at least—to the ano-rectal area, that it is not surprising that pregnancy may cause anal or rectal disorders. As Dr. Gerendasy here points out, the proctologist has a definite contribution to make to good obstetrical care.

The intimate relation of proctology to obstetrics has not received the consideration which it deserves. A review of some of these relations may result in an early recognition of, and better treatment of anorectal complications of pregnancy.

The anorectal region shares the anatomic and physiologic changes which occur in the pelvic organs during pregnancy. The female perineum is composed of the urogenital diaphragm anteriorly and the levator ani and anal musculatures posteriorly. These muscles undergo hypertrophy and increased elasticity as pregnancy advances to permit the muscular distention and dilatation necessary for normal delivery. These muscles normally also support and resist the downward force of the intra-abdominal pressure and the weight of the pregnant uterus. Weakness of these muscles may result in a sagging pelvic floor with relaxation of the vaginal outlet and the formation of a cystocele or a rectocele. This exposes the external genitalia and the anorectum to injury and infection during and after pregnancy. The consequence of such infection may be any of the anorectal diseases enumerated below.

In addition, the loss of the propulsive power of the pelvic muscles as well as the relaxation of the abdominal muscle (with diastasis recti) which accompanies repeated pregnancies, makes the act of defecation difficult and the associated constipation is conducive to anorectal disease.

The collateral vascular supply to the pelvic organs and the anorectum are markedly increased during pregnancy. Hypertrophy of these vessels and consequent engorgement and dilatation occur. As a result of postural changes (spinal lordosis) and the increased weight of the pregnant uterus, pressure against the portal circulation causes venous stasis which is conducive to vascular complication, *e.g.* hemorrhoids. A rectum filled with hard fecal matter may likewise cause such a complication and for the same reason.

The hormonal changes of pregnancy induce increased glandular activity of the vaginal, rectal and anal secretory cells. The consequent moisture becomes a fertile field for mycotic or bacterial infection. The former is a frequent cause of pruritus ani during pregnancy.

Importance of Symptoms: The obstetrician frequently does not attach sufficient significance to anorectal symptoms in the pregnant and parous woman. In many instances an anal lesion goes unrecognized and untreated because the anal outlet has not been examined. When an anal lesion *is* found its significance must be evaluated and it is here that the proctolo-

gist can be of service in estimating the importance of such a lesion and in suggesting treatment.

The following symptoms occurring during pregnancy and postpartum suggest anorectal complications. Proctologic consultation is then indicated. *Pain,* which usually indicates the lesion to be in the anal canal or perianal tissues; *bleeding, a* frequent symptom of anorectal disease such as hemorrhoids, fissure, adenoma and especially carcinoma; *pruritus ani* in pregnancy is usually due to increased glandular activity of the vaginal, rectal and anal secretory cells with, frequently, superimposed mycotic infection and occasionally a bacterial infection; *discharge,* whether mucous, purulent or bloody is a cardinal symptom requiring determination of cause; *protrusion from the rectum,* suggests hemorrhoids, rectal mucosal prolapse or polyp; *swelling,* may be due to abscess, anal hematoma or infected skin tags; *diarrhea,* may be due to obstruction caused by the pregnant uterus, malignancy or enteritis; *constipation,* which may be the cause of or may be caused by many rectal or extrarectal conditions.

The anal lesions most frequently observed[1] as a complication of pregnancy are, in the order of frequency: (1) hemorrhoids; (2) infection of the crypts of Morgagni; (3) edematous (infected) skin tags, usually containing multiple thrombi; (4) fissure-in-ano or ulcer; (5) pruritus ani; (6) rectal mucosal prolapse; (7) condyloma acuminata.

THE remote symptoms caused by colorectal disease during pregnancy are not sufficiently appreciated. These referred symptoms occur more frequently in the gastrointestinal tract.[2] Fissure, cryptitis, hemorrhoids and other anorectal infections may give rise to impaired bowel function with dyspeptic symptoms such as "bilious" attacks with headache, flatulence, heartburn, irritability, nausea and anorexia. These lesions also give rise to symptoms which simulate organic disease such as acute appendicitis and cholecystitis. They may lead to abdominal operations that could have been avoided if a proctologic consultation had been requested. An anorectal examination would have properly evaluated the findings and the extra hazard to pregnancy eliminated.

Indications for Treatment of Anorectal Disease. The proctologist may be of assistance in evaluating the seriousness of anorectal disease and recommending methods of treatment. He may be equally helpful in advising *against* operation under certain circumstances such as the presence of anorectal disease in a pregnant patient with ulcerative colitis. The proctologist has to point out that surgery may cause exacerbation of the disease.

He may also recommend prophylactic measures during pregnancy in order to avoid colorectal complications. These include good oral hygiene for proper mastication, and the regulation of bowel function preferably by dietary means. Since anal soilage (fecal and leukorrheal) is a frequent cause of local irritation and infection, peri-anal cleanliness and vaginal douches are indicated.

Suggestions for medical measures in the treatment of anal disease during pregnancy rather than surgical treatment are also functions of the proctologic consultant. Medical treatment may be prescribed for: acute fissure, pruritus ani, minimal condyloma acuminata, and uncomplicated bleeding hemorrhoids where the use of a sclerosing solution will relieve this condition.

Indications for Surgery. Surgical intervention during pregnancy and the puerperium when indicated is now a recognized procedure especially for a disabling condition such as anal hematoma, acute abscess, crypt abscess, adenomatous polyp of the colon, extensive perianal and perineal condyloma acuminata which may interfere with normal delivery. Surgery may be safely performed during the first and second trimester. Because of the marked vascularity and fragility of the tissues in the third trimester, surgery should then be postponed, except as an emergency measure, at least six weeks postpartum. When such a procedure is

1. Gerendasy, J.: Bulletin of the Margaret Hague Maternity Hospital, 9:197 (Oct. 1956).
2. Gerendasy, J.: JOURNAL of The Medical Society of New Jersey, 47:421 (Sept. 1950).
3. Schneider, H. C.: Journal of the International College of Surgeons, 27:755 (June 1957).

decided upon it should be performed preferably under local procaine hyaluronidase[3] infiltration anesthesia or procaine solution with Cobefrin hydrochloride® (Winthrop).

CONCLUSION

THERE is an intimate relation between the female pelvic organs and the terminal bowel. There is a tendency for the development of anorectal complications or the aggravation of pre-existing disease as the result of trauma incident to pregnancy, labor and delivery.

It is recommended that a routine inspection, digital palpation and anoscopy of the rectum should be performed in all pregnant and parous women, particularly with rectal symptoms. When a diseased condition is ascertained it would seem desirable that the obstetrician and the obstetrical staff avail themselves of the informed knowledge of the proctologist. His function is to evaluate and recommend treatment of anorectal complications.

12 Clifton Place

Mastectomy May Spread Tumor

Writing in the 1959 Texas State Journal of Medicine (55:101) T. H. Thomason asks whether radical breast amputation is worthwhile—and concludes that it is. A breast lump may or may not be out of bounds when diagnosed as malignant. Assuming that metastasis has not occurred, radical mastectomy offers the one chance of eradicating the disease. Simple mastectomy—which is not always "simple"—by cutting across the main paths of lymphatic drainage, is more likely to spread cancer cells than is a well planned radical operation.

Cancer of the breast is considered inoperable if there is evidence of:

- Edema of the skin involving more than one-third of the breast tissue
- Satellite nodules in breast skin
- Inflammatory carcinoma
- Metastasis to supraclavicular nodes
- Metastasis to internal mammary nodes
- Metastasis to lungs
- Edema of arm
- Skeletal metastasis or pain in back or pelvis suggesting metastasis
- Liver enlargement suggestive of metastasis

Any *two* or more of the following:

- Ulceration of the skin
- Edema of the skin involving less than one-third of the breast
- Fixation of tumor to chest wall
- Fixation of axillary nodes to skin or deeper structures
- Axiliary nodes exceeding 2.5 cm. in diameter.

The Invisible Skin Disease

Silicon hair curlers may produce an invisible but terribly painful skin disease among hairdressers, two University of Pennsylvania dermatologists warn.

Writing in the August 8, 1959 *Journal of the American Medical Association*, Drs. Walter B. Shelley and Donald M. Pillsbury said the disease consists of excessively sensitive fingertips, although the skin shows no sign of disease. This is due to tiny particles of silica which becomes embedded in the top layer of the skin, irritating the sensory nerve endings. The particles rub off silica or sand-coated hair curlers, which have replaced plastic curlers in many beauty shops. This invisible skin disease "may become common among beauticians unless efforts are taken to eliminate this new occupational hazard."

In one case, a 40-year old woman first noted a marked sensitivity of the fingertips to light touch. Eventually all the fingertips became involved. Pain and inflammatory changes were absent, but exquisite tenderness to touch eventually forced her to stop working.

At first it was thought the patient had a neurologic or vascular condition. Treatment with local anesthetic and steroid creams was unavailing. Microscopic examination of the fingertips showed the tiny particles embedded in the skin. Then the patient remembered that the condition had begun about the time she had started using sand-coated curlers instead of plastic curlers.

Treatment consisted of removing the very top layer of skin by microsurgery.

Robert K. Spiro, M.D.

Bloomfield

Post-Operative Parotitis

Postoperative parotitis is a rare complication of surgery, but an uncomfortable one. Dr. Spiro here draws lessons learned by analyzing all such cases in a five-year period at The Mountainside Hospital.

Postoperative parotitis is an uncommon complication of surgery, but one of real significance. It carries a high morbidity and is frequently prognostic of a poor outcome.

Seriously ill, dehydrated, undernourished patients with poor mouth hygiene are prey to postoperative parotitis. A dirty oral cavity seems to trigger the onset of the disease. The highest incidence has occurred after abdominal [1] or genito-urinary surgery.[2]

The staphylococcus has almost routinely been the bacterial cause, both during the pre-antibiotic era [3] and subsequently, when resistant strains have developed and been found on routine study in members of the hospital family.[4] It is generally felt that the pathogenesis of parotitis includes ascending infection *via* Stensen's duct from the mouth. Curveilhier first stated this view in 1842. Prolonged trauma from pressure on the gland by the anesthetist at the time of surgery has also been suggested [5] as a contributing factor.

The largest of the salivary glands, the parotids, secrete watery saliva low in mucin. A tough capsule surrounds the gland, thus permitting extensive gland damage before fluctuation is evident. Gangrene of the gland may occur, sometimes with damage to the facial nerve.[3]

A tender, swollen gland occurring about four to six days following surgery suggests the disease. Fever may be noted and pain may be localized to the gland. One or both glands may be simultaneously involved. The papilla of Stensen's duct may be swollen and red. Leucocytosis is recorded, and pressure on the gland may, at the duct opening, yield pus which cultures Staphylococcus aureus.

Prevention of the disease is the best therapy. Adequate fluid intake prior to surgery, and as soon as feasible after surgery, is essential. The health of the teeth and the mouth should be good before major elective surgery.

After the condition has been established, therapy continues to include good fluid balance and oral hygiene. Salivary secretion is enhanced by means of chewing hard candy or gum. Cold and warm packs are alternately applied to the involved gland area. Antibiotics selected in accord with any bacterial culture and sensitivity data available are also used.

Early surgical drainage and splitting of the capsule was advocated in 1923 by Blair and Padgett [6] and in 1917 by Lilienthal.[7] In essence, it consists of a hockey-stick incision started just anterior to the ear and curving beneath the mandible. The parotid capsule is split. Pus and edema together or singly will be obtained, providing consider-

*From the Department of Surgery, The Mountainside Hospital, Montclair, New Jersey.

1. Rankin, F. W. and Palmer, B. M.: Annals of Surgery, 92:1007 (1930).

2. Gustafson, J. R.: *Surgery*, 29:786 (1951).

3. Coughlin, W. T. and Gish, E. R.: Archives of Surgery, 45:361 (1942).

4. Howe, C. W.: New England Journal of Medicine: 251:411 (1954).

5. Gilchrist, R. K. and McAndrew, J. R.: Archives of Surgery, 76:863 (1958).

6. Blair, V. P. and Padgett, E. C.: Archives of Surgery, 7:1 (1923).

7. Lilienthal, H.: American Journal of Surgery, 31:101 (1917).

able relief to the patient in a few hours following gland decompression. The wound is packed with iodoform gauze. Salivary fistulae have not been a problem and the wound is cosmetically acceptable. Endotracheal or local anesthesia may be used. Postoperative care includes soaking and irrigation of the wound with saline each day.

Hodges [8] in 1924, used radium and/or x-ray therapy for parotitis. This has been very effective in many cases.

The following abstracts briefly illustrate experience with this disease in the 5-year period ending June 30, 1959 at The Mountainside Hospital in Montclair. Approximately twenty-two thousand operations were performed during this period, using general or regional anesthesia. Five cases of postoperative parotitis occurred. Four patients had intra-abdominal surgery and one had genito-urinary surgery.

CASE REPORTS

1. An eighty-two year old woman had an anterior resection of the sigmoid for carcinoma on May 18, 1956. Operative time was four hours. Inhalation anesthesia *via* endotracheal tube was used. Postoperatively naso-gastric suction was employed for six days. On May 23, swelling and tenderness developed in her left parotid area. There was no toxicity. Oral Chloromycetin®, one Gram daily, and x-radiation to the area, 150 r. daily, brough subsidence in four days. No culture of parotid secretion was done.

2. A fifty-eight year old man was circumcised on December 27, 1956. Saddle block anesthesia was used. He developed left parotid tenderness and swelling two days after surgery. Penicillin G and dihydrostreptomycin† 2 cubic centimeters twice daily, administered intramuscularly brought relief in forty-eight hours. No culture of parotid secretion was done.

3. An exploratory laparotomy was done on June 6, 1958 on a seventy-one year old woman. Carcinoma of the peritoneum associated with carcinoma of the ovary was found. Inhalation anesthesia was used. A biopsy of omentum was done. Ten days later, spinal anesthesia was used for a colostomy. On July 3, she developed signs of right parotitis. Tenderness and swelling of the gland were evident. Hemolytic staphylococcus aureus was isolated from pus in Stensen's duct. Chloromycetin® and penicillin were given in addition to mouth irrigation with sodium borate (Dobell's) solution. Improvement in the parotid condition occurred, but the patient died on July 8, from her basic disease.

4. On July 16, 1958, a fifty-eight year old bartender underwent subtotal-gastrectomy for chronic intractable painful duodenal ulcer. A catheter duodenostomy was done because of poor tissue for duodenal stump closure. The patient developed a sub-phrenic abscess which was drained on July 30. Anesthesia was administered by inhalation for both operations. Evidence of bilateral fulminating parotitis developed on August 8. The patient became very toxic and disoriented. Intravenous Chloromycetin® was used, and each gland received 250 roentgens of external radiation on each of four successive days. No real improvement was noted. On August 15, incision and drainage of the glands was done under local anesthesia. Pus and edema fluid were obtained. Cultures were positive for hemolytic staphylococcus aureus, already cultured from the right Stensen's duct. The patient became less toxic the next day and gradually improved. He was discharged twelve days following parotid surgery. There was no more purulent drainage. The glands then were nearly normal in size and consistency. Surgical drainage of the parotids was felt important to the salvage of this patient.

5. A fifty-three year old female underwent bilateral salpingo-oophorectomy and incidental appendectomy in an attempt to control carcinoma of the breast on May 21, 1959. A radical mastectomy had been done previously. Inhalation anesthesia was used. Two days after surgery, right parotid tenderness and swelling occurred. This subsided in four days following use of warm saline mouth irrigation frequently.

The experience at The Mountainside Hospital, Montclair, with postoperative parotitis, has fortunately not been extensive during the past five years. This complication may occur at varying intervals after surgery. It is more prone to develop in persons having some other chronic catabolic process placing extra strain on the total organism. Staphylococci were isolated from gland secretions in several instances. Early recognition and therapy can minimize the morbidity associated with this complication of surgery.

SUMMARY

FIVE cases of postoperative parotitis are presented. Comment is made on the pathogenesis of the disease and its care. Prophylactic steps directed toward its prevention are urged, particularly in patients having a chronic disease.

59 Fremont Street

†Available under the Pfizer tradename of Combiotic®.

8. Hodges, F. M.: American Journal of Roentgenology, 35:144 (1936).

Historical Aricle • • •

Susan Joan Gordon
Ventnor

The "Sack-'Em-Up" Boys

This oft-told story is ever new, and it is good for us to be reminded now and then of this gruesome episode in our professional history. Miss Gordon tells the story simply and accurately.

As late as the beginning of the nineteenth century, anatomic material for dissection was provided almost entirely by grave robbers or "resurrectionists."[1] These men were so proficient in their distasteful work that they could, with the aid of a trusty crowbar, open a coffin, remove the body, and replace the shroud and the casket so skillfully that many tears were shed and many flowers were planted over empty graves.

Public feeling was frenzied against "resurrectionists." Sometimes, when they had been taken prisoner, they were torn from the hands of the constables and beaten or even hanged.[2] Fresh graves were watched at night so that the corpses would be protected from grave robbers or from over-zealous medical students who wished to gain favor with some teacher. Countless contraptions were conceived to safeguard the graves of loved ones from the ravages of body traffickers. These devices included "mortsafes," which were strong iron bars that surrounded the tombs, and Bridgman's patented wrought-iron coffins.[3] However, the bodies still continued to disappear. The high prices paid for cadavers by anatomists made taking the risks worthwhile. The black-market on bodies was a lucrative venture and "resurrectionists" were rife.

The surgeons of England were at the mercy of the "resurrectionists" because there were no adequate laws to provide cadavers for them. The only competition to which the grave robbers were subjected was that offered by the King, when, in the beginning of the nineteenth century, bodies of executed felons were made available for dissection.[4] This law, however, met with great dissatisfaction and it was soon dropped.

The body dealers of England were an unpleasant lot. One such dealer, named Merrilees, sold his sister to the surgeons.[5]

One case history concerned Dr. Robert Knox, professor of anatomy at Edinburgh University. Dr. Knox was a dynamic teacher, and his extraordinary way of teaching the "new method" of anatomy attracted large numbers of students to his classrooms.[6] This overabundance of students made it difficult for him to get enough cadavers to supplement his lectures. To eliminate this need, he did business with two rascals named Burke and Hare and their wives.

Hare owned a boarding house and inn in Edinburgh. The unscrupulous pair arrived at

1. Baas, J. H.: *Outline of the History of Medicine and the Medical Profession*, New York, William R. Jenkins Co., 1910, p. 555.
2. Robinson, V.: *The Story of Medicine*, New York, The New Home Library, 1943, p. 377.
3. Ibid. p. 377.
4. Gordon, B. L.: *The Romance of Medicine*, Phila., F. A. Davis Co., 1944, p. 74.
5. Robinson, V.: Opus cited, p. 378.
6. Castiglioni, A.: *A History of Medicine*, New York, Alfred Knopf, 1941, p. 676.

the idea of doing business with Dr. Knox when on old army pensioner named Donald, who was a resident of the inn, died with no relatives or friends to care for his body.[7] Donald, at the time of his demise, allegedly owed Hare four pounds. To recoup his losses, Mr. Hare sold his body to Dr. Knox for seven pounds ten shillings,[8] which had a nominal value of $50 in the early nineteenth century, representing $100 or more at today's level.

Seeing that money was easy to obtain in this manner, the two hit upon a scheme which took the lives of sixteen persons before it was halted. They decided to kill people who, they felt, had no reason to live, and to peddle their bodies to the doctor.

THE first victim was another lodger, Joseph the Miller. He was sick with "fever." Burke and Hare held a conclave and decided that there was no valid reason to keep the poor soul alive. They terminated his suffering by smothering him. Burke pressed one hand tightly over his victim's nostrils and applied pressure to the back of his neck with the other hand. This method of killing is still known today as "burking."[9]

The next three victims were a nameless Englishman suffering from jaundice; Abigail Simpson, who sold salt in the streets of Edinburgh; and Effie, an old cinder gatherer. The last two were destroyed by the method that became the trademark for the Burke-Hare Enterprises. The victims were invited in for a sociable drink by Mrs. Hare and were so intoxicated that they fell into a stuporous sleep. While they slept, William Burke gently suffocated them. Dr. Knox was pleased by the fresh state of the bodies. He discreetly failed to ask any questions as to their origin for fear that the pair would take their business elsewhere.[10]

Fortune smiled on the Burke-Hare organization. One day Burke saw a poor inebriate being dragged off to prison by a constable. Here was opportunity knocking at the door and Burke did not require a second knock. He told the minion of the law that he knew where the woman lived and would gladly take her home. He took her to his home, and the following morning Knox owned her.

In her zeal, Mrs. Hare even went as far as to suggest that Mrs. Burke be turned into capital assets for the firm. Mr. Burke was too fond of his Nelly to permit this.[11] However, Ann M'Dougal, a relative of Nelly Burke, came to visit her kinswoman and was welcomed with open arms and whisky bottles. Although Burke usually committed the murders, he nobly declined to kill a distant relative. He deferred to Hare for the commencement of the murder; but to set the matter right, he completed the job himself.[12]

Mary Haldane, a stout old street walker, never refused a drink, and the women of the enterprise plied her with more than one. Two days later, her daughter, Peggy, called to find out what had happened to Mary, as she had been seen entering the inn. The kindly Burke informed her that her mother had come and gone, but Peggy was certainly welcome to come in and have a drink while talking the situation over. Indeed, Mr. Burke helped Peggy Haldane to find her mother.[13]

ONCE when Burke was leading a forlorn old man to the inn, he saw a woman and her dumb son walking alone. He took the mother home for a drink. The next morning the young boy showed by his actions that he was alarmed at being left alone. Burke knew that the boy could not cry out, so, while he looked on with frightened, imploring eyes, Burke took him on his knee and snapped his cervical vertebrae. This was the simplest and most direct of the killings. Dr. Knox paid sixteen pounds for the two bodies.

Public opinion was finally aroused by the next murder. James Wilson, a lad of eighteen, was given the nickname of Daft Jamie. He was thought to be mentally defective, but he was simply an overly sensitive boy. He was

7. Robinson, V.: *Op cit.* p. 379.
8. *Encyclopaedia Britannica,* Chicago, Encyclopaedia Britannica, Inc., 1952, Vol. 4, p. 422.
9. Garrison, F. H.: *An Introduction to the History of Medicine,* Philadelphia, Saunders, 1914, p. 382.
10. Robinson, V.: *Op cit.* p. 380.
11. Ibid. p. 381.
12. Ibid. p. 381.
13. Ibid. p. 382.

even frightened of children, but he trusted implicitly in adults. Mrs. Hare took advantage of that trust and she led him into the inn. Her plans were upset when Jamie refused to drink. The assassins were forced to kill him by overpowering him in unison. Everyone in Edinburgh had known and had liked Daft Jamie. Dr. Knox paid ten pounds for Jamie's body —more than the boy had seen in all his life.[14]

Suspicion was first aroused with the murder of Mary Paterson, an attractive young prostitute. When this body was delivered to the doctor, one of his students recognized it as a girl with whom he had been out only a few nights previously. Still the discreet doctor asked no questions. Mary Paterson's body was preserved as the best illustration of the female form.[15]

THE last murder was that of a little old lady named Docherty. She had come to Edinburgh to find her son. Burke told her that his name was Docherty, also, and suggested that they must be related. The noble Burke said that he would glady help her find her son and offered her the hospitality of his home. The weary lady gratefully accepted the friendly offer. Her body was discovered by a lodger in the inn named Gray. He was offered a bribe to remain silent, but he went to the police. A sergeant examined the place where the body was alleged to have been, but it was gone. Traces of blood were found on the straw, but Mrs. Burke explained by saying that she was menstruating. The constable said he believed her, but he took everyone into custody just to be certain.

The whole story finally came out due to Gray's incorruptibility. A collection was taken up for him. It is an unfortunate testimony to the times that less than ten pounds was collected—less than Knox would have paid for one body.

At the trial, Hare was persuaded to turn king's evidence, and he smilingly admitted sixteen murders. Hare, Mrs. Hare, and Mrs. Burke got off scot free; Burke was hanged. His body was given to Dr. Alexander Monro for dissection. His short, squat skeleton still hangs in the University of Edinburgh next to that of Daft Jamie.[16]

Dr. Knox was technically guiltless, but his medical career was ruined. He received many threatening letters and only his most faithful students remained loyal. He later defended himself in print, but his apologia fell on deaf ears and he was through with medicine for life.

One great good came out of all this horror. In 1832 Lord Warburton's Anatomy Act was passed, which provided that all unclaimed bodies should, under specified circumstances, go to medical schools. This ended the careers of the "resurrectionists" and a macabre era of British medical history.[17]

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14. Garrison, F. H.: *Op. cit.* p. 382.
15. Robinson, V.: *Op. cit.* p. 383.
16. Ibid, p. 386.
17. Garrison, F. H.: *Op. cit.* p. 383.

6917 Atlantic Avenue

Trustees' Meeting: February 21, 1960

At its February 21 meeting the Trustees:

—Voted to restrict distribution of unverified Board minutes to members of the Board, and to continue the wider distribution after minutes have been ratified.

—Notified the New Jersey CIO Council that it was opposed to the Forand Bill.

—Approved the action of the President in indicating that he could not serve on the local sponsoring committee for the National Council on Social Welfare.

—Received from the State Nurses' Association an invitation to join the faculty of workshops in professional nursing.

—Voted to encourage hospitals to establish committees for the control of nosocomial infections.

—Accepted the report of the Permanent Committee on Blue Cross and Blue Shield plans with respect to the proposed senior citizen contract.

—Requested MSP to continue vigorous efforts (in the eleven counties not yet included) to encourage 51 per cent of the physicians to participate in the senior citizen contract.

—Directed the calling of a special meeting of the House of Delegates to consider the proposed joint diagnostic rider.

—Authorized our council on public relations to buy and distribute decalcomanias, for automobile use, with two prints to each member, additional ones on request.

—Received from the Executive Officer a report that the American Medical Association had established a Commission on the Cost of Medical Care.

—Approved supplemental agreements to Medicare.

—Reviewed the qualifications needed for the post of Director of the State Division of Mental Deficiency and directed that this be sent to the Civil Service Commission:

> The Director of the Division of Mental Deficiency, New Jersey State Department of Institutions and Agencies, shall have a doctorate in medicine received in course as a result of four years' sequential attendance in a recognized medical school, one year of internship in a recognized hospital, and a license as a Doctor of Medicine to practice medicine and surgery in New Jersey.
>
> Following this the physician should have devoted himself to three years of specialized training in neuropsychiatry and practiced this specialty in private practice for an additional two years leading to his eligibility for certification by the American Board of Neurology and Psychiatry. He preferably should have devoted himself primarily to and demonstrated his continuing interest in mental deficiency in all of its aspects. It is our opinion that the Director of such a Division should be aware of recent advances in the medical differential diagnoses within the concept of mental deficiency and have a sound framework of reference in genetics, neurology, pharmacology, electro-physiology, neurosurgery, and therapeutics. This is imperative since in the past several decades promising new developments have occurred and more are anticipated in the future which make it mandatory that someone with a very broad based perspective in these fields and in clinical psychiatric experience would be desirable.

—Approved in principle a suggested "Relative Value Index and Preamble."

—Received and noted a resolution from the Ocean County Medical Society opposing a rider for diagnostic services in the Blue Cross contract.

—Received from M.S.P. board a memorandum to the effect that their Public Relations Office had been directed to report monthly "on steps taken by it to improve the public relations representation of Medical-Surgical Plan."

—Received from M.S.P. board a note indicating that they would ask to amend their bylaws increasing by one their Trustees, and making the President of The Medical Society of New Jersey the additional MSP trustee.

—Noted that the Interprofessional (physicians and lawyers) "Code" had now been adopted by 17 of our 21 component societies —the most recent ones being Camden, Hudson, Middlesex, Ocean, Salem and Sussex.

—Authorized our President to send letters

to the New Jersey delegates to both major political party conventions informing the delegates that our Society is opposed to Forand-type legislation and asking them to do all they can to keep the subject from favorable mention in the platform.

—Received from our Counsel, Mr. Backes, the following report on the extent to which standard professional liability insurance protects physicians in supervisory and administrative functions:

"From my research, it would appear that there are no controlling cases in point, therefore, my opinion must necessarily be without definity. From the policy itself the obligation of the company is to pay . . .

"All sums which the insured shall become legally obligated to pay as damages because of injury arising out of malpractice, error, or mistake in rendering or failing to render professional services in the practice of the insured's profession . . . committed during the policy period by the insured or by any person for whose acts or omissions the insured is legally responsible . . ."

"and the policy does not apply to

"liability of the insured as proprietor, superintendent, or executive officer of any hospital, sanitarium, clinic with bed-board facilities, laboratory, or other business enterprise."

It is quite clear from the statements of the agents that the company's intention is to limit its coverage only to the "doctor-patient relationship." However, in view of the fact that our courts of law follow a policy of construing a written instrument most strictly against the company which has prepared it, it is my opinion that regardless of their expressed intention, the words of the policy itself would control and that a strict construction of the words referred to above would not necessarily limit coverage to the doctor-patient relationship, for it does seem that there are many so-called administrative functions and responsibilities that a staff doctor performs and assumes without a direct doctor-patient relationship which could not necessarily be described as those of "proprietor, superintendent, or executive officer of a hospital."

New Citations for Dr. Read

Hilton S. Read, M.D., Director of the Ventnor Diagnostic Center, and Executive Director of the Ventnor Foundation which since 1951 has brought 463 carefully selected recent graduates of medicine from Western Germany, Austria and Switzerland medical universities to the United States for one year internship, was awarded an honorary degree of Doctor of Medicine by the University of Cologne, with the following citation:

"The Medical Faculty of the University of Cologne during its meeting on February 17, 1960, decided unanimously to confer upon you the honorary degree of Doctor of Medicine.
This is a high honor very rarely bestowed on anyone by the universities of our country. In making this presentation we express our gratitude to you for your efforts in establishing contacts in the field of medicine and also human bonds between your country and Germany. Your endeavors will never be forgotten. During the period of greatest material and cultural need in Germany you have made it possible for many young doctors to get to know your great country and its excellent medical institutions and to have thorough contact with the progressive ideas of your countrymen. As the present Dean of the Medical Faculty I consider it a privilege to inform you of the honor bestowed on you.

Sincerely yours,
Professor Dr. C. Kaufmann,
Dean"

On June 18th, 1955, Marburg University awarded Dr. Read the Phillips Medal and on May 17th, 1956, he was the recipient of the Edgar J. Ill Award of the Academy of Medicine of New Jersey, as an "Educator in Democracy through Medicine."

Referral of School Children for Eye Care

Prepared and Recommended by

COMMITTEE ON CONSERVATION OF VISION
OF THE MEDICAL SOCIETY OF NEW JERSEY

New Jersey Revised Statutes 18:14-57—"The medical inspector or the nurse under the immediate direction of the medical inspector shall examine every pupil to determine whether any physical defects exist."

REFERRAL OF SCHOOL CHILDREN FOR EYE CARE

The medical examination of the school child is an accepted practice, endorsed by the medical profession and required by state law in New Jersey. The school physician is concerned with the mental and physical health of the child. The importance of the sense of sight in learning is universally recognized. School authorities have taken particular interest in the health and function of the visual system—the eyes and the visual pathways and areas in the brain. Screening for ocular diseases and defects is but a part of the *general medical program* of screening school children for physical defects and evidence of disease. The eyes and the brain are parts of the *whole child.*

Complete ocular examination of every child by the ophthalmologist, beginning in infancy and repeated periodically is desirable, but is not yet universal practice. Until parents recognize this need there will be a need to identify those school children who particularly need attention. School screening is not a substitute for complete medical examination of the eyes The purpose of screening is to find and refer for diagnostic examination those children who probably have an abnormal condition of the visual system from whatever cause.

Children should be referred for examination if the *acuity of vision is impaired* (a condition which may be due to refractive error or to disease) or if there is any condition likely to *impair binocular vision* or handicap the use of the eyes for *close work.* Some conditions can be detected by tests, but others require medical inspection or the observation of signs or symptoms. An adequate screening program requires inclusion of all of these methods. It is the purpose of this report to outline such a program. *A child may have normal vision yet have ocular disease urgently requiring medical attention.* He may have impaired vision and not complain of it. He may have double vision and not report it, but reveal signs of difficulty to the trained eye of the general physician. He may show no signs on medical inspection, have good vision, but show signs of eye trouble in the classroom situation.

PARENT-TEACHER OBSERVATION

Since the school medical program is in no sense diagnostic, parents who observe any abnormal signs or whose children report symptoms should take their children for examination and evaluation by the family physician or ophthalmologist without awaiting the results of the school medical program. Similarly, whenever eye signs are observed by the teacher, the child should be referred for examination directly. If such a child "passes" a screening test this does not alter the need for referral for examination and diagnosis.

Whenever the teacher observes any of the following signs, the child should be referred to the parents with recommendation for eye examination:

a. Crossed eye, "wandering" eye, "cast," even though not constant.
b. Excessive blinking, or squinting.
c. Red eyes or eyelids, or frequent styes.
d. Rubbing or wiping eyes frequently.
e. Apparent difficulty in seeing what is on blackboard, or inability to see small detail in near vision or stumbling.
f. Persistent frowning, especially in reading.
g. Persistent reading difficulty, especially if there are signs suggestive of a possible ocular basis; e.g., word omission or repetition, transposition in the line, jumping lines, repeating lines or misplacement of a word to line above or below

Whenever the teacher is in doubt, or whenever she observes any other eye condition she suspects may be a factor in the education of the child she should refer the child to the school physician, or to the school nurse, if the physician is not available, without waiting for routine screening tests.

If the child reports any of the following an eye examination is indicated:

a. Cannot see well.
b. Words, letters or lines "run together" or "jump."
c. Double vision.
d. Vision blurs (especially after period of reading).
e. Headache or other symptoms after work involving continuous near vision.

Children who fail in their studies or who in other ways fail to succeed in school life should be referred to the family physician even though the entire medical screening program (including the eye screening which is merely a part of it) yields negative results. Such children deserve individual detailed medical examination. It is then the responsibility of the family physician to arrange for any and all special investigations which may be required. These may include, among others, special psychiatric examination or laboratory tests.

MEDICAL INSPECTION

An examination of the eyes is part of every general medical examination including the periodic physical examination by the family physician or the school physician. The physician's observation of a need for further examination is conclusive, regardless of what vision screening tests may show.

The physician should observe the behavior of the eyes as a test object is moved in the cardinal directions of gaze, and as the object is brought from a distance of about 18 inches to within 2 inches of the nose. Failure of both eyes to follow the test object indicates possible impaired binocular coordination. The physician should recheck abnormal findings to be certain inattention or some other irrelevant factor is not giving a false impression of motor abnormality.

Functional screening tests will identify many children with abnormal conditions which escape detection by observation of signs and symptoms. Testing may be delegated to the nurse by the physician, but is only a part of the eye screening of the general medical program. The physician's overall responsibility cannot be delegated to someone with less than the medical training of the physician. The interpretation of the results and determination of need for further medical examination is medical responsibility.

CRITERIA FOR TESTS

It is important that appropriate tests be selected and that they be simple, especially in the lower grades. The following criteria for evaluating tests have been suggested:

"1. The *test should be valid.* It should function and bear relation to clinical knowledge.
"2. *The test should be reliable.* It should give similar results on repetition.
"3. *A nurse or layman should be able to administer the test* (under the physician's direction) *with a minimum of training.*
"4. *The test should consume a minimum of time consistent with ascertaining the necessary information.*
"5. *The test should lead to a minimum of 'over-referrals.'*
"6. The method should avoid the appearance of indicating diagnosis or degree of defect, either to the parents or the lay person administering the test."*

Such combination of procedures and tests should be employed as will detect as many proper referrals as possible.

THE VISUAL ACUITY TEST

The visual acuity test not only identifies more children requiring referral than any other single test, but the majority of such children and identifies them with few errors. It is done most effectively by the standard Snellen chart (letters or E characters) for use at a physical distance of 20 feet. A visual acuity test is actually the chief test in all test batteries and instruments which have been offered for school screening.

The illumination of the chart should be standardized, preferably at twenty foot candles. Testing should be limited to the critical lines for pass or fail. The tester should not attempt to determine what the visual acuity is—a diagnostic procedure—but whether or not the child can read the test line. Failures should be retested on another day before referral. Test-

* Quoted with permission from "Report No. 7: Identification of School Children Requiring Eye Care," a detailed study of the subject published by the National Medical Foundation for Eye Care. Copies of the report may be obtained directly from the Foundation, 250 W. 57th Street, New York 19, New York.

ing should not be done immediately after strenuous physical exertion or exposure to bright sunlight.

The vision of each eye is tested separately. If the child has glasses the test should be done only with the glasses. If the visual acuity of either eye is less than 20/30 in grades 1-3, and less than 20/20 in either eye in school grades 4 and above, the child should be referred for examination. If one eye meets this average normal standard, but the other eye is decidedly better, the child should be referred; in such a child the better eye should be taken as the "normal" for that child.

Not all children who will be referred will be found to require eyeglasses or other treatment, but determination of the significance of small deviations from the normal is the responsibility of the physician who makes the diagnostic examination. Lower referral standards will reduce the total number of children referred as well as the percentage who will be found to require no treatment, but will permit conditions actually detectable by the test to escape detection (and so provide the occasion for criticism of the test itself) and will result in failure to refer some children who do require treatment.

The Snellen acuity test leads to relatively few referrals of children who do not have an ocular condition to be evaluated. There is no substitute for this test. It should always be done.

Tests for acuity of vision at the near point are not indicated in school screening. Impaired near vision in children is usually due to conditions for which the standard Snellen visual acuity test and the convex lens test are specific.

CONVEX LENS TEST

Some refractive errors do not cause impairment of acuity of distance vision, but may cause discomfort or blurring in reading or both. Because children do not always recognize or voluntarily report their symptoms, the use of a test to detect such defects of "farsightedness" is justified. The child may require no treatment, but should be referred for examination.

Hyperopia or "farsightedness" may be detected by the convex lens test. The convex lens test should be performed *only* on children whose vision is found to be *unimpaired* in either eye by the visual acuity test. (It has no screening significance in children who fail the visual acuity test.) This test is performed by having the child read the Snellen chart with both eyes open while wearing convex lenses. (If the child wears glasses, the test lenses are worn over the glasses.)

Farsightedness is common in children and frequently does not require glasses. Therefore not all farsighted children should be referred, but only those whose farsightedness might be significant. Ophthalmologists generally accept the use of lenses of the order of +2.0 diopters. If while wearing the lenses the child reads the test line stated above for his grade he should be referred for examination.

The convex lens test is recommended as the best method of identifying children with hyperopia who are not identified by the visual acuity test.

BINOCULAR VISION TESTS

Children with frank strabismus or other disturbances of binocular vision frequently have significant hyperopia, or impaired vision in one eye or both eyes (due to refractive error or disease), or "normal" but unequal vision, and so are detected by the Snellen test or the convex lens test. Others will be detected by the observation of the parents or the teacher and the inspection of the family physician and the school physician.

Lateral heterophoria or "latent muscle imbalance" is not of itself an abnormal condition. It is usually adequately compensated in the child, regardless of amount, by "fusional vergence," the coordinating mechanism. When fusional vergence is inadequate, there may be discomfort or difficulty in reading, such as word omission or repetition or transposition in the line, or blurring of distance or near vision, or double vision. These are ocular signs which should be recognized as an indication for referral regardless of the results of the tests. Lateral heterophoria testing with distance fixation may indirectly detect some oculomotor conditions warranting evaluation, but it is not a satisfactory method of screening.

There is no satisfactory screening test for *inadequate fusional vergence*. Hence parent-teacher observation and the school physician's functional examination of eye movement and controlled convergence are extremely important.

Hyperphoria or vertical "muscle imbalance" may give rise directly to difficulty in reading —jumping of lines, misplacement of a word to line above or below. These ocular signs are

also an indication for referral. Hyperphoria can be tested for in screening. The test screens out such a small percentage of children (about 0.5%) that the question of over-referral is not an issue. When it is employed, referral for hyperphoria of the order of greater than 1 prism diopter is recommended.

It takes only a few seconds to test for hyperphoria. (With some test equipment the test is done simultaneously with a test for lateral heterophoria. Such combined tests refer about 2 per cent of the school population; although some will be erroneous referrals, it will be evident that the number involved cannot be large.)

Such limited muscle balance tests can be done with simple equipment employing the Maddox rod or red-green glasses and targets. In the present state of our knowledge consideration should be given to all factors and the use of these tests should be determined by the individual school physician with ophthalmologic consultation.

Lateral heterophoria tests at the near point, and other binocular screening tests with or without a stereoscope are not indicated because they do not meet the stated criteria for tests.

INSTRUMENTS AND EQUIPMENT

The Snellen chart with fixed illumination is required to meet the needs in school screening. Convex lens spectacles are readily obtainable on the order of a physician. Satisfactory commercial modification of the standard Snellen test, with built-in illumination in package units supplying convex lenses (and equipment for muscle balance tests if desired) are available. The school physician should determine what tests are to be done in the specific school system. Ophthalmologic consultation is always available.*

The use of stereoscopic instruments has sometimes been suggested on the theory that these instruments simplify testing. Actually, they complicate the testing procedure by introducing sources of error. Stereoscopic instruments do not make available any valid referral test which is not available without the stereoscope, but they offer a different mechanical means of testing. In school systems where this equipment is available and its continued use is preferred, it is recommended that any tests provided with the instrument, other than the tests described above, be omitted.

Any program will be most effective if it is applied under the guidance of an ophthalmologist in a consulting capacity. It is neither necessary nor desirable that screening examination or testing be done by an ophthalmologist. His presence, as an expert, would suggest to parents that the screening procedure is a diagnostic ophthalmologic examination. For the same reason nonmedical refractionists, opticians, or technicians or "visual examiners," who might be confused with the ophthalmologist or be regarded as experts should not participate in screening.) The nurse who administers the tests is responsible to the school physician. The determination of the validity of tests and the establishment of referral standards is a medical responsibility.

REPORTING THE TEST

Failure to find indication for referral does not establish that the child has no abnormality. No report should be sent to the parents unless the child is referred for examination. Whenever any part of the school medical screening program indicates a need for referral, parents should be informed that further medical examination is advisable. Statements of visual acuity are *not* advisable. Test results under screening conditions may differ from the findings on clinical examination. Parents seeking confirmation from the physician of test results reported by the school may misinterpret such differences.

SCHOOL-PHYSICIAN-PARENT RELATIONS

Parents, school personnel, and the medical profession must all understand (1) the nature and objective of the eye health program; (2) the contributions each individual has to make, and (3) the role of the school physician (medical inspector) and his staff.

The Parents—Parents should clearly understand that theirs is the first responsibility. They should be informed as to the difference between screening and thorough ocular examination. They must understand that failure to pass a screening test means merely that examination by the physician is indicated and that observation of signs of ocular difficulty by parent,

* Information concerning instruments and school testing procedures can be obtained by writing to the Special Committee on Conservation of Vision, The Medical Society of New Jersey, P.O. Box 904, Trenton 5, N. J.

teacher or school physician indicates examination in any case. The health of the eyes, the state of vision, and whether treatment is necessary, as in the case of the child's general health, can be determined only by the physician after examination. Parents should not look to the school for this information.

An educational program to acquaint the parents with what to observe in their children and the importance of taking the child for examination when the school advises it is recommended.

The School—It is recommended that the school avail itself of consultation with members of the medical profession. In a sound program designed to screen those who are to be evaluated, and not those who are to be treated, there will be some referrals of children who, on examination by the physician, will be found to require no treatment. This must be understood. It should be pointed out to parents especially when any new program is instituted. Some error in referral or failure to refer will occur with the most ideal method. They may result from human failure, from error of observation by the child or the examiner.

The Medical Profession—Ophthalmologists should take precaution in the manner of their reporting negative examination to the parents. The school should be *credited* for referring children for examination, rather than discredited for an occasional inevitable error of referral of a normal child, or for the referral of cases which prove not to require treatment. Conversely, when the ophthalmologist finds on examination of a child that medical care is required, and the child was not referred by the school, the physician can contribute to the parents' understanding by pointing out that screening procedures are not diagnostic and cannot be infallible.

The examiner should furnish the school necessary information about the child's eyes. The school needs to know:

(1) that the examination has been done;
(2) under what circumstances glasses are required in school, if this is the case;
(3) what, if any, special consideration (e.g., seating in the classroom) or special teaching (e.g., program for partially sighted) the child requires;
(4) what limitations, if any, are placed on the child's activities and school attendance.

It is neither necessary nor desirable that the ophthalmologist render to the school a full medical report of his diagnostic procedures and therapy. They are without meaning unless interpreted by the physician and even then generally of no value to the educator. The administration, the teaching staff, and the guidance personnel want to know what, if any, limitations the child has and what the school can do to help. If additional information as to diagnosis and findings is required by the school, the school physician, with the consent of the child's parents, can obtain this from the examining physician.

Ophthalmologists should recognize a responsibility to offer their advice and assistance to the health departments and schools when approached for such help. They should provide instruction for school medical personnel. In acquainting parents and school personnel as to what they should observe in a child's appearance and behavior, or otherwise rendering assistance, the ophthalmologist will be discharging an obligation as a physician to his community.

FOLLOWUP

Nothing has been accomplished for the referred child if parents fail to take him for examination. Where effective educational measures introduce the school eye health program, a better response will be obtained from the parents when examination of the eyes is advised. When the school fails to receive a report that the examination has been done, followup by the nurse is advisable. The school nurse is particularly qualified by training and public acceptance to acquaint the parents with the need and with their responsibility.

Periodic ophthalmologic examination of every child is advisable and for this there is no substitute. It is recommended that every child have an examination by an ophthalmologist *before* entering the kindergarten. Blindness in one eye is more prevalent among children than is generally realized. In a high percentage of cases it is due to conditions which arise in infancy or early childhood and pass unnoticed. If these conditions are diagnosed early, adequate medical treatment can usually prevent this blindness. Ophthalmologic examination of every child in the third year will substantially contribute to this objective.

Approved by Special Committee on Conservation of Vision, Council on Public Health, and Board of Trustees, The Medical Society of New Jersey—September, 1959.

Supplementary List No. 3
to the
1959-60 Membership Directory

Memberships reported from December 11, 1959 through April 10, 1960

R—Reinstated
N—New

	Name	Address	County	Practice
		ACTIVE MEMBERS		
R	Ayers, John R., Jr.	394 Branch Ave., Little Silver	Monmouth	Gen Psy
R	Babcock, George, Jr.	4 Balsam Pl., North Caldwell	Union	Research
N	Battin, Keith G.	609 Greenwood Ave., Trenton	Mercer	....
N	Bauer, Stanley	900 Lydia Ave., Bronx, N. Y.	Essex	....
N	Becker, Melchior E., Jr.	E. I. DuPont de Nemours Co., Gibbstown	Gloucester	Ind
N	Berry, Bradley D.	103 Mahwah Rd., Mahwah	Bergen	General
N	Bosco, Louis G.	32 Bergen Ave., Jersey City	Hudson	....
R	Braga, Gennaro F.	230 W. Jersey St., Elizabeth	Union	Gen Surg
N	Braun, Frederick C., Jr.	1143 W. Valleybrook Rd., Haddonfield	Essex	....
R	Brunkow, Charles D.	31 Lincoln Park, Newark	Essex	Urol
R	Calderone, Joseph P.	10 W. Gibbons St., Linden	Union	General
N	Caton, John E.	Box 65, Belle Mead	Somerset	....
N	Chirls, Marvin	72B De Mott St., Tenafly	Essex	....
N	Clark, William K.	530 Maple Ave., Ridgewood	Bergen	General
R	Colburn, Daniel W.	1 Grumman Ave., Newark	Essex	General
R	Colmer, Meyer J.	32 North Ave., Elizabeth	Essex	Anes
N	Debbie, Anthony G.	915 Prospect Ave., Plainfield	Union	....
N	Drucker, Paul	77 Durand Pl., Irvington	Essex	Resident
R	Feigenbaum, Jerrold M.	39 Bayview Ave., Newark	Essex	Resident
N	Ficke, John R.	U. S. Army Hosp., Ft. Lee, Va.	Essex	....
N	Gallagher, John R.	175 Somerset Dr., Levittown	Burlington	....
R	Gandler, Alfred L.	603 Watchung Ave., Plainfield	Union	Int Med
R	Gardner, Jack C.	733-35 W. Fourth St., Plainfield	Union	Int Med
R	Garfinkel, Burton	1156 Liberty Ave., Hillside	Union	Rad
R	Garofalo, James L.	107 Smull Ave., Caldwell	Essex	Research
N	Getmanov, Valentina	777 Boulevard E., Weehawken	Hudson	....
N	Gialanella, Robert R.	369 Roseville Ave., Newark	Essex	Int Med, GE
N	Goklen, Mehmet F.	714 Kearny Ave., Kearny	Essex	Int Med, Card
N	Gotchel, Richard P.	Greenfields Prof. Bldg., Mantua Pike, Woodbury	Gloucester	Ob, Gyn
R	Graupner, Robert D.	556 Morris Ave., Summit	Sussex	Research
R	Guito, Francis J.	626 Mattison Ave., Asbury Park	Monmouth	General
R	Hilliard, William T.	105 Market St., Salem	Salem	General
N	Hutcheon, Duncan E.	24 Baldwin Ave., Jersey City	Hudson	Teach, Res
N	Inzinna, Joseph F.	433 Lawton Ave., Cliffside Park	Hudson	....
R	Johnson, Matthew E.	906 Stokes Ave., Collingswood	Camden	....
N	Kaiser, Frank F., Jr.	505 E. Broad St., Westfield	Union	Surg
R	Knapp, Herbert A.	500 Third Avenue, Bradley Beach	Monmouth	General
R	Krug, Alfred J.	942 Sanford Ave., Irvington	Essex	Orth
N	Levine, Samuel	117 County Park Dr., Cranford	Union	....
N	Levinson, Gilbert E.	100 Clifton Pl., Jersey City	Hudson	Card Teach, Res

R	Litvak, Henry W.	649 Mattison Ave., Asbury Park	Monmouth	Urol
N	Lockhart, Gordon M.	77 E. Main St., Marlton	Burlington	....
N	Lorello, Robert J.	313 Fabyan Pl., Newark	Essex	Resident
N	Lo Verme, Stephen R.	299 S. Harrison St., East Orange	Essex	Plas, Recons Surg
R	Majeski, Anthony J.	The Roosevelt Hosp., New York, N. Y.	Essex	....
N	Maurice, Peter	83 Gates Ave., Jersey City	Hudson	....
R	Meeker, John H.	1571 Mt. Eagle Pl., Alexandria, Va.	Essex	General
N	Meier, Carl	125 Hamilton St., Bound Brook	Somerset	....
N	Moscr, Harvey S.	3347 Park Ave., Union City	Hudson	General
N	Moss, Stewart	Dover Rd., Mount Freedom	Essex	....
R	Nardi, Michael E.	710 Station Avc., Haddon Heights	Camden	General
R	Norman, N. Allen	763 Norwood Ave., Elberon	Monmouth	General
N	Nychay, Stephen	111 Van Nostrand Ave., Jersey City	Hudson	Anes
N	Panico, Frederick G.	101 S. Indiana Ave., Atlantic City	Atlantic	Thor, Cardio Vas Surg
R	Parker, James W., Jr.	179 Shrewsbury Ave., Red Bank	Monmouth	General
N	Porter, Samuel	7 Pleasant Valley Dr., Woodbury	Gloucester	....
N	Primich, Frederic F.	6515 Boulevard E., West New York	Hudson	....
R	Raymond, Joseph	10966 Roebling Ave., Los Angeles, Cal.	Union	....
R	Richardson, Marvin T.	177 S. Livingston Ave., Livingston	Essex	General
N	Rothfeld, Edwin L.	1677 Walker Ave., Union	Essex	Resident
N	Ruhl, Forster G.	151 Summit Ave., Summit	Union	Ob, Gyn
N	Ruvolo, Anthony	33 Prince St., Elizabeth	Union	Anes
R	Rymar, Dargo	435 Second St., Lakewood	Ocean	General
R	Sacco, Gregory E.	191 Broad St., Red Bank	Monmouth	EENT
R	Schorr, Herman E.	79-11 41st Ave., Elmhurst. N. Y.	Hudson	General
N	Scialli, Vincent A.	460 Passaic Ave., Passaic	Passaic	Anes
N	Sckalor, Martin	569 Montgomery St., Jersey City	Hudson	....
N	Scudder, Harry G.	109 E. Shore Trail, Sparta (Lake Mohawk)	Camden	Govt
R	Shaul, John F.	Camelia Circle, Hobrow Point, Mt. Pleasant, S. C.	Essex	U. S. Navy
N	Stahl, Martin B.	511 New Brunswick Ave., Perth Amboy	Middlesex	Ob, Gyn
N	Stevenson, Stuart S.	24 Baldwin Ave., Jersey City	Hudson	Teach, Res
N	Susskind, Bernard	7027 A Glenmeadow La., Cincinnati, O.	Essex	Resident
N	Tabbanor, Edward R.	21 Clinton Pl., Newark	Essex	Resident
R	Tierney, Charles V.	11 Bailey Rd., Millburn	Essex	Ob, Gyn
N	Vanose, Frank C.	6101 Boulevard E., West New York	Hudson	....
N	Wax-Schlam, Florence S.	139 Beechwood Rd., Oradell	Bergen	Ped
R	Weeks, Belford A.	315 S. Shore Rd., Absecon	Atlantic	....
N	Wcems, Don B., Jr.	107 E. Mantua Ave., Wenonah	Gloucester	General
N	Wimer, Bruce M.	9 Parmley Pl., Summit	Union	Int Med
R	Winter, Arthur	377 S. Harrison St., East Orange	Essex	Neur Surg
R	Wyatt, Joseph H.	135 Clinton Ave., Newark	Essex	Rad
N	Zankiw, Wolodymyr	1885 Hudson Blvd., Jersey City	Hudson	General

Alpert, Elmer	Box 452, Autumn Hill Rd., Princeton	Mercer	....
Barlow, Bernard G.	2 Surrey La., Levittown	Burlington	General
Belsky, Murray E.	1 Maples Ave., Newark	Essex	....
Benes, Joseph H.	308 Engle St., Englewood	Bergen	Urol
Block, Ralph N.	506 Ramapo Valley Rd., Oakland	Passaic	General
Boylan, Joseph I., Jr.	1471 Gregory Ave., Union	Essex	....
Brady, Matthew A.	517 S. 18th St., Newark	Essex	....
Brandon, Ralph F.	Naval Supply Center, Bayonne	Essex	Govt
Brisco, Margaret	Martland Medical Center, Newark	Essex	....
Calluori, Enio F. U.	441 Roseville Ave., Newark	Essex	....
Carlin, Robert A.	1423 Irving St., Rahway	Union	....
Carno, Irving H.	310 W. Jersey St., Elizabeth	Union	Int Med
Challener, William A., III	129 Summit Ave., Summit	Union	Int Med
Chang, Owen A.	2190 Riverton Rd. (Cinnaminson Twp.), Riverton	Burlington	General
Chorkawa, Anna I.	82 Richelieu Pl., Newark	Essex	Ped
Cianfarro, Vincent	N. J. State Hosp. (Ancora), Hammonton	Camden	Hosp
Clark, Samuel, Jr.	96 Washington Ave., Westwood	Bergen	....
Cole, Sanford H.	2 Custer Ave., Newark	Essex	....
Conti, Peter C.	15 Walters St., Bergenfield	Bergen	General
Costabile, Douglas M.	336 Mountain Ave., Murray Hill	Union	....
Daubert, James J.	19 Holly St., Cranford	Union	General
De Luca, Ralph	86 Garside St., Newark	Essex	....
Dorian, Robert V.	155 W. Hobart Gap Rd., Livingston	Essex	Resident
Dougherty, Louis J.	123 Prospect St., Ridgewood	Bergen	Urol
Dunkelman, Robert	22 Main St., Bloomingdale	Passaic	General
Eckbold, Norman H.	S. Jersey Med Ctr, Rt 70 at Barclay Farms, Haddonfield	Camden	Orth Surg
Ehrenworth, Lionel	230 W. Jersey St., Elizabeth	Union	Int Med, Hematol
Eisenstodt, Howard M.	1458 Parkview Ter., Hillside	Essex	....
Esposito, William J.	151 Summit Ave., Summit	Union	Rad
Everhart, Dean A.	122 State St., West Englewood	Bergen	General
Fessas, Alexander K.	1144 Mary St., Elizabeth	Union	Gen Surg
Fink, Sidney	750 Broadway, Paterson	Passaic	Int Med
Flamm, George G.	440 Cooper St., Beverly	Burlington	General
Fogel, Richard L.	500 S. Centre St., Orange	Essex	....
Frank, Robert L.	514 Cooper St., Camden	Camden	Oph
Gabe, Jutta A.	Cooper Hosp., Camden	Camden	Anes
Gelber, Robert D.	41 Elizabeth St., Pemberton	Burlington	General
Gerlaugh, Robert L.	333 Park St., Upper Montclair	Essex	Urol
Gibney, Patricia M.	59 Mounthaven Dr., Livingston	Morris	Anes
Goldman, Jerrold G.	Beth Israel Hosp., Newark	Essex	....
Goldman, Stanton C.	2265 Baird Blvd., Camden	Camden	....
Gradone, Francesco P.	49 Midland Pl., Newark	Essex	....

Green, Philip S.	639 Irvington Ave., Newark	Essex	Resident
Guss, Sheldon	Babies' Hosp., Newark	Essex	....
Hanlon, Robert J.	Martland Medical Center, Newark	Essex	....
Harami, Theodore Ch.	528 Broadway, Paterson	Passaic	Ob, Gyn
Harrington, Alida H.	2 S. Hampton Dr., Levittown	Burlington	....
Harris, Joseph T.	754 Scotland Rd., Orange	Essex	....
Hasbrouck, Walter H.	190 Cooper Ave., Upper Montclair	Essex	Ind
Herman, Anna	951 Queen Anne Rd., Teaneck	Bergen	....
Hessert, Edmund C.	1212 Chesterfield Rd., Haddonfield	Camden	Resident
Holland, Albert H.	22 E. 40th St., New York, N. Y.	Morris	Phar Res
Hurowitz, Bertram D.	1719 Walker Ave., Union	Essex	Resident
Incecian, Vincent	327 Beechwood Rd., Oradell	Bergen	Ob, Gyn
Iula, Frank A.	25 Black Horse Pike, Haddon Heights	Camden	General
Jacobs, Martin G.	111 Longview St., West Orange	Essex	Resident
Janis, Michel	St. Elizabeth Hosp., Elizabeth	Union	Path
Johnson, Donald H.	West Jersey Hosp., Camden	Camden	Anes
Kalman, Harold	Carlton Pl. cor. Greenwood Ave., Edison	Middlesex	General
Kerdasha, Robert G.	274 Essex St., Hackensack	Bergen	....
Kienle, Jane W.	S. Jersey Med Ctr, Rt 70 at Barclay Farms, Haddonfield	Camden	Psy
Koppisch, Arthur R.	272 E. Second Ave., Roselle	Union	Ped
Kuziw, Tuhan M.	St. Michael's Hosp., Newark	Essex	....
Lilien, Robert L.	124 Tuxedo Pkwy., Newark	Essex	....
Lissner, Arthur B.	355 N. Fullerton Ave., Upper Montclair	Essex	Resident
Mancinelli, Ralph T.	267 Highland Ave., Orange	Essex	....
Mazzei, Lawrence J.	793 Harvard Pl., Cliffside Park	Essex	Resident
Metrione, Durand A., Jr.	112 Park St., West Caldwell	Essex	....
Morris, Robert H.	500 S. Centre St., Orange	Essex	Resident
Mulvaney, Robert B. J.	25 Longfellow Ave., Newark	Essex	Resident
Newman, Richard	39 McClellan Terr., West Orange	Essex	Resident
Nucci, Cyrus G.	24 Grove St., Bloomfield	Essex	....
Paglia, Michael A.	125 S. Centre St., South Orange	Essex	Resident
Palumbo, Pasquale	8470 S.W. 33rd Ter., Miami, Fla.	Essex	....
Pannullo, Traudel E.	22 Ferry St., Newark	Essex	Ob, Gyn
Parsonnet, Mia	206 Millburn Ave., Millburn	Essex	General
Pawluk, Orest M.	13 Oriole Way, Moorestown	Burlington	Psy, Neur
Petrowski, John T.	100 Passaic Ave., Passaic	Essex	Ob, Gyn
Petti, Matthew	178 Colonia Rd., Colonia	Union	....
Pilecki, Joseph A.	198 Main St., South River	Middlesex	....
Rabin, Martin	65 Manor Dr., Newark	Essex	Resident
Raso, Joseph A.	389 Grand St., Paterson	Passaic	General
Redfield, Ernest S.	Cooper Hosp., Camden	Camden	Path
Rescigno, F. Peter	418A Mt. Prospect Ave., Newark	Essex	Int Med, Hematol

Obituaries • • •

DR. DAVID J. CARLOUGH

One of Passaic County's oldest physicians died on March 17. Dr. David Jacobus Carlough was born in Paterson in 1869—when Andrew Johnson was finishing his term as President and Ulysses S. Grant was being inaugurated. In 1892 he received a baccalaureate degree from Wesleyan and entered Yale Divinity School intending to become a clergyman. He later opted for medicine and in 1895 was graduated from New York Medical College. After a New York internship, he returned to his native city, and served the people of Passaic County for half a century. His late wife (she died a month earlier) was also a well-known Paterson physician—Edna Cowan Carlough.

DR. DAVID R. CROUNSE

Dr. David Ryerson Crounse was born only two years after the death of Abraham Lincoln. In 1895 he was graduated from Columbia University's College of Physicians and Surgeons, and after interning in Buffalo, New York, returned to Passaic to go into general practice. As was the custom in those days, he was also a dispenser of medications, and was a partner in one of Passaic's pioneer pharmaceutical establishments. He was a charter member of St. Mary's Hospital staff. One of Dr. Crounse's boasts was that for 50 years, he never refused a night call. He was well known as a golfer and hunter, and was active in civic affairs as well as in the work of the Passaic County Medical Society. Dr. Crounse died on March 9, 1960.

DR. HERBERT KATZ

Born in Paterson in 1911, Herbert Katz earned a baccalaureate degree at the University of Pennsylvania in 1931. In 1935 he received his M.D. from the University of Michigan and, after his internship won an affiliation in neurology at the Vanderbilt Clinic in New York City. He did postgraduate work in both neurology and psychiatry and was elected to membership in the American Psychiatric Association. In 1944 he began to show evidences of multiple sclerosis. Within three years he was substantially confined to a wheel-chair, but was able to carry on as a psychotherapist until recently when the progress of his illness led to extensive disability. He then became a patient at the Daughters of Miriam Home, where, on March 20, he was finally released from his ailment.

DR. GEORGE MEEHAN

Dr. George Edward Meehan died suddenly on March 27, at the age of 64. Born in Jersey City in 1896, Dr. Meehan was graduated in 1922 from the medical school of Georgetown University. He affiliated with the Jersey City Medical Center soon after completing his internship there, and served the people of Hudson County for a decade. He then moved to Monmouth County and built up a busy general practice in the Spring Lake - Asbury Park area. Dr. Meehan was active in civic affairs, and at the time of his death was treasurer of the Monmouth County Democratic Committee. He was interested in church affairs and had a period of service as president of the Holy Name Society of his parish. Dr. Meehan was proud to be considered a family doctor, but his special interests were in internal medicine and in industrial health.

DR. NATHAN SALZMAN

Dr. Nathan Salzman was one of our state's pioneer radiologists. He was born in New York in 1893 and died at his home in Paterson on March 16. He received his M.D. at Bellevue in 1920, and accepted an internship at Barnert Hospital that year. He was never thereafter disassociated from the Barnert staff. He was instrumental in developing modern x-ray technics both at Barnert and at Passaic Beth Israel, and for 35 years served as chief of radiology and roentgenology at Barnert. He was active in affairs of the Passaic County Medical Society as well as in a number of civic and religious organizations.

DR. WALTER D. WEBER

Dr. Walter D. Weber of Union City died on March 4 at the age of 72.

Born in Hoboken in 1887, Dr. Weber received his early education in Union City schools and received his medical degree from the University of the State of New York, College of Medicine in 1910. He interned at Bellevue and Christ Hospitals and was on the staff of the latter. An active and vigorous leader in organized medicine, he was President of the Hudson County Medical Society in 1944 and 1945. At the time of his death he was in line to receive the Golden Merit Award of The Medical Society of New Jersey.

Letters to The Journal • • •

"An Air of Specialization"

DEAR SIR:

Twenty-four hundred years ago Herodotus wrote of the Egyptian customs in medicine: "The country swarms with doctors—they have a doctor for the nose, a doctor for the abdomen, a doctor for the head—and they only treat that one."

This is *fast* becoming true today. A decade ago the "family doctor" (general practitioner) was thought of as one who could set fractures, snare out a pair of tonsils, and perform an appendectomy. Today in medicine there has been created an air of specialization and super-specialization.

The G.P. makes the initial diagnosis and prescribes the proper care and treatment. But surgery, when required, is referred to the proper surgeon or specialist. The G.P. is being taken away from his specialty of interest and placed on G.P. service. Here he can no longer serve as an assistant or associate in his specialty.

To specialize and to be so rated by the American Board of Examiners, he must, after his regular internship, devote three more years to a residency before he can obtain his rating and establish his practice. Boards are reluctant to accredit preceptorships in lieu of residency. Preceptorship could include graduate courses while engaged in private practice. Preceptorship, in any field, should be accepted as it has been for the past hundred years.

The G.P. of today, while actively engaged in his regular work, has facilities nearby to enable him to pursue special fields through conferences, courses or clinical work. In most instances he is a dedicated man, with the welfare of his patient placed above monetary gain. In larger communities, friction between the specialist and the G.P. is growing. The specialist forgets that he too was once a G.P. The novice specialist, not having the G. P. rating, will find it difficult to obtain referrals.

In many large hospitals today, specialists heading a department are asked to retire at the age of 65. Inasmuch as no pension fund exists, these men are forced to do limited surgery and may probably return to general practice.

There is ample room for both specialists and the G.P. and they should work in closer harmony both in the interest of medicine and of the public, the G.P. performing such surgery as he feels qualified to do, and referring more difficult patients to the specialist, who returns the patients to the G.P. after surgery. The public, as a whole, is growing resentful of the high fees charged by the specialist. Unless better relations are established, the public will lean toward socialized medicine. It behooves both the specialist and the G.P. to look at the picture from all angles for the good of the profession as a whole and not in a particular field of specialization.

R. J. AMATO, M.D.
Newark

"Playing Political Payola"

DEAR SIR:

The majority of Americans believe in state rights and state responsibilities. They are members of a sovereign state by the terms of a compact called the United States Constitution. These traditional concepts are now threatened by a federal bureaucracy likely to engulf us all.

If you are not aware of this menace, take a hard look at what has happened to state rights in our lifetime. The Old Deal, the New Deal and the Square Deal have each dealt progressive blows to individual freedom and witnessed the assumption by big government of responsibilities hitherto those of the individual states.

Nowhere is this more striking than in the field of medicine. Social Security, originally a depression measure to benefit a small low-income group has accumulated a cost that now

rivals the national debt and well wishers would now add to this, free hospital and surgical care for senior card holders. The cost is somewhere between one and five billion dollars a year.

Underlying this move is the assumption that government can tax away whatever it needs and what remains to the private sector will take care of everything else. A little reflection will show this just isn't so. If it becomes politically impossible to restrain the pressure of public demands the result will be a steady dissipation of available funds. The question then is how long a financial crisis can be forestalled and at what point national medical service will become an added item.

Both public and profession should know that a federal program of either hospital or medical care would bring about profound changes in the practice of medicine and in the operation of hospitals. For a blue print, a report entitled *Medical Care Insurance*, published as Senate Committee Print No. 5 (79th Congress), should be read. In it is every detail for national health insurance including organization of hospitals, physicians, patients, nurses and druggists, as well as methods of remuneration, types of benefits, restrictions and appeals. In a phrase: the machinery for federal control.

No one will deny that the economic problem of medical care for the aged is one deserving of intensive and careful study. This it has been receiving, without fanfare or hysterics, from medical and lay groups throughout the country. Nor is the problem one of economics alone. "Let the government do it," has become the attitude of many families without love, interest or a sense of responsibility for the senior members.

Let's stop playing political payola and give our senior citizens the time and thought their problems deserve. To make them the pawn in an election year is a disservice and an insult.

Robert B. Marin, M.D.
Montclair

Antepartum Laboratory Work Under Medicare

The Journal has been notified of the following modification of the *Medicare Manual*. This is identified as "Modification 56 in code 4822" and refers to antepartum care. As modified the note reads:

Necessary drugs which are administered parenterally by the physician rendering the care may be charged separately *at cost* to him by listing on the billing form. If physician accomplishes the necessary *laboratory work* in his office, he may charge for this service on his billing form. Routine return visit urinalyses are not reimbursable, as they are included in the obstetrical fee. When a physician procures laboratory service, other than routine return visit urinalysis, from a source which is not authorized to bill a fiscal administrator directly, the physician may add the cost to him of these procedures on his billing form. Physicians directing laboratories are authorized to submit claims for services rendered direct to a fiscal administrator.

South African Medical Directory Available

For the first time there is now available a directory of all physicians in South Africa, with biographic data about each. This nicely bound volume cost $7.50 plus $1.00 postage from the Knox Printing Company, 30 Baker St., Durban, Natal, South Africa.

Announcements • • •

Cancer of Early Life

Announcement is made of the Ninth Annual Kaplan Lecture to be delivered at 5:30 p.m. on Thursday, May 26 at Alumni Hall, New York University School of Medicine, First Avenue at 31 Street, New York City. The essayist will be Dr. Sidney Farber, Professor of Pathology at Harvard. His subject is listed as: "Biologic and Therapeutic Considerations of Cancer in Early Life." All physicians are welcome to attend the lecture which is sponsored by the Radiologic Alumni of Bellevue.

Armed Forces Still Need Physicians

General Hershey wants young doctors to know that the Armed Forces still need them. Those deferred for residency training may expect early calls. Of course, shortages vary with the specialty. Since 1957, the Armed Forces have not requisitioned doctors through Selective Service, but if the Forces cannot get enough through voluntary application, draft may have to be reactivated. For more information write to Selective Service System, Washington 25, D. C., or phone Dudley 6-3445, in Washington.

Language Disorders in Children

On May 27, at 4 p.m., a symposium will be held on language disorders in children. This will be at the School for the Deaf, 223 East 23 St., New York City. For details, write to Dr. Julia Vinograd, 1845 East 21 Road, Long Island City 5, Queens, N. Y. Principal speaker at this symposium will be Dr. H. K. Mykelbust, nationally known director of Northwestern University's Institute of Language Disorders. Moderator will be William Barger, M.D., a consultant in speech disorders, at the Essex County (N.J.) Guidance Center. Physicians, social workers, teachers and psychologists are all welcome.

Doctors' Nurses to Convene

June 23 to 25 has been selected as the dates for the next meeting of the American Association of Doctors' Nurses. The place: Hotel Deauville in Miami. The program includes papers on quackery, on early detection of cancer in the female, and on psychiatric topics. A boat-trip over inland waters is provided by a chartered yacht. Also available: visits to Jamaica and Nassau. For details, write to American Ass'n. of Doctors' Nurses, 409 Farragut Building, Washington, D. C.

Arthritis Fellowships

Interested in research in arthritis? If so, you may be eligible for one of the awards of the Arthritis and Rheumatism Foundation. For details, write to Medical Director, Arthritis and Rheumatism Foundation at 10 Columbus Circle, New York 19, N. Y.

Opportunity for Psychiatrist

A part-time appointment is available as medical director of the Lakeland Guidance Center in Pompton Lakes, N. J. An excellent salary is offered to a New Jersey-licensed physician with mental health clinic experience. If interested, write to Dr. Jeanette G. Yedinack, 930 Pines Lake Drive West in Wayne (Passaic County), N. J.

Rheumatic Disease Bulletin Available

Any physician interested in this may receive without charge the monthly "Bulletin on Rheumatic Diseases," by writing to the Arthritis and Rheumatism Foundation at 10 Columbus Circle, New York 19. A collection of the bulletins will eventually constitute a valuable textbook of rheumatology.

County Society Reports • • •

Bergen

The regular meeting of the *Bergen County Medical Society* held April 12 at Bergen Pines Hospital, Paramus, was called to order by Donald B. Hull, M.D., president at 9 p.m., in the presence of 82 members.

The minutes of the regular meeting of March 8 and those of the Executive Committee meeting of March 15, were accepted as printed in the April *Bulletin*.

The Secretary read the following names which had been approved for election to membership:

To Associate: Joseph John LoFaro, Gene-Ann Polk, Francis Campbell Symonds, Jr.

The Secretary was instructed to cast one ballot for the election of these candidates.

Dr. Olpp discussed present actions on the Forand Bill. He pointed up the recent political scramble in both parties to get on Old Age Benefits and stated that new legislation would likely be proposed in the near future.

A reply to a letter to Representative Widnall from Dr. Shenkman, was read in which a question was asked about inability of older people to get health insurance. Decision was that Dr. Shenkman should reply with assistance of Medical Society Office.

Dr. Olpp listed reasons for our County Society to belong to the U. S. Chamber of Commerce and so moved. Motion was defeated after some discussion.

Dr. Verdon made a first reading of changes in By-Laws. This would replace the term regular member with active member wherever it appears in the By-Laws.

It was proposed to add the following to 5, II of our By-Laws:

> Any false or misleading statements or information contained in the written application for membership or supplied by applicant to the Society or Membership Committee shall be grounds for rejection of such application, or expulsion of a member if, subsequent to such member's election to membership, statements or information contained in such member's application or supplied by applicant to the Society or Membership Committee, shall be determined to be false or misleading.

Dr. Heller moved a resolution on the evaluation of national medical and para-medical fund raising groups, as a service to both public and doctors. This motion was adopted.

The Secretary read a motion about widening sale of Medical-Surgical Plan riders to non-group subscribers, and so moved. This was seconded and accepted by vote.

Dr. George Heller, Chairman of the Nominating Committee presented the following panel of candidates for 1960-61: *President*—George Rowohlt; *First Vice-President*—Walter Wahrenberger; *Second Vice-President*—Samuel B. Reich; *Secretary*—Charles P. Campbell; *Treasurer*—John P. O'Connor; *Assistant Treasurer*—Alfred A. Alessi; *Judicial Committee*—Leo J. Fitzpatrick.

These names are placed in nomination for election at the Annual Meeting in May at which time additional names may be placed in nomination from the floor.

President Hull turned the meeting over to Dr. Reich, Chairman of the Program Committee, who introduced Dr. Irving Klompus, Chairman, Council on Medical Services of The Medical Society of New Jersey. Dr. Klompus outlined the background of "relative value scales." He stated that the New Jersey Relative Value Index was two years in the making and was done with the help of twenty one specialty groups and AAGP. He hoped that our House of Delegates whould adopt the Relative Value Index. He pointed out that acceptance by the State Society would not make the scale compulsory.

Many questions followed and these were answered by Dr. Klompus and by Dr. Gannon (another Medical Society of New Jersey committee member) at some length.

The President thanked all concerned and the meeting was adjourned at 10:45 p.m.

CHARLES P. CAMPBELL, M.D.
Reporter

Burlington

The *Burlington County Medical Society* met at the Millside Farms Dairy on March 10 for its regular monthly meeting. Dr. J. R. Shanahan of the University of Pennsylvania gave a lucid, clear and fascinating talk on "gout" filling in for Dr. Flippin at the last minute. He discussed the newer medications and left us all with a much clearer idea of the pathogenesis of the disease and of how we could best alleviate it. A very long business meeting followed.

Dr. J. Howard Hornberger, Chairman of the Constitution and By-Laws Committee, gave a second reading of the proposed changes in the Constitution and By-Laws. After considerable discussion and minor changes, these were all accepted. They had to do primarily with the technical aspects of membership, associate membership and forwarding of names to responsible A.M.A. and state membership committees. It was decided that we did not have to have by constitution any "standing committees." The number of committees and their membership will be at the discretion of the current president. The new constitution calls for the office of Second Vice-President. Dr. Keith

Young, Burlington, was elected to that post.

A motion was made to discontinue the present nursing scholarship which has been maintained by the Medical Society for the last nine years. It was distressing to learn that not a single one of the nurses whom we had sponsored is presently engaged in active nursing work within the county. The Medical Society has offered and given a $150 annual scholarship to each of three nurses. The total expenditure is thus about $450 per year. The Society voted to discontinue the nursing scholarships after all present scholarship holders had finished training. Discussion then centered on the question of support of the Homemakers' Service. The Woman's Auxiliary has just completed organizing such a service and schooling is to start next month. The Burlington County Medical Society voted to appropriate $800 for the Homemakers Service. This has just been organized as an independent organization with a self-perpetuating board under the sponsorship of the County Medical Society and its Auxiliary. The Society felt that this organization ought to be strongly encouraged and underwritten. It was also felt that it would be valuable for public relations.

A budget for next year was read and adopted.

Dr. Burton A. Kramholz and Dr. Henry Cohan were elected to membership as transfers from other Societies.

Following a social hour with refreshments the meeting was adjourned.

LINDLEY B. REAGAN, M.D.
Reporter

Gloucester

The regular monthly meeting of the *Gloucester County Medical Society* was held February 18 at the Woodbury Country Club with Dr. Dorothy M. Rogers presiding. A moment of silence was observed in memory of Dr. Harry Nelson, a beloved member of our Society, who passed away on January 7.

The program for the evening consisted of several presentations of local talent. Three of our own members, Dr. Samuelson, Dr. Gotchel, and Dr. Regan gave interesting discussions. Dr. Chester Samuelson spoke on the "Significance of Transverse Process of the Seventh Cervical Vertebra." Dr. Richard Gotchel's topic was "Single-Dose Caudal Anesthesia in Obstetrics." Dr. Cornelius Regan spoke on toxic manifestations of local anesthesia.

The Society decided that local talent night should be included in the program for the following year. The business section followed, during which our new executive secretary, Mrs. Mae Clements, was introduced. Treasurer's report showed a balance in the treasury of $7261. Communications were read and the meeting was then adjourned.

WILLIAM D. KEHLER, M.D.
Reporter

Mercer

A regular meeting of the *Mercer County Component Medical Society* was held at the State Society building, Trenton, April 13, Dr. John A. Kinczel, President, presiding.

Dr. Durant K. Charleroy, a member of the Council on Medical Services of The Medical Society of New Jersey, presented a resume of the Relative Value Index to clarify many misunderstandings relative to its purpose.

During the business portion of the meeting, a resolution was unanimously adopted in accordance with which members of the Mercer County Component Medical Society will refuse to renew Medical-Surgical Plan contracts as participating physicians, should Assembly Bill 556 be enacted into law. The Secretary was directed to forward the resolution to F. Clyde Bowers, M.D., President, The Medical Society of New Jersey, with the request that it be presented for action at the next meeting of the House of Delegates in order that the physicians of New Jersey be urged to cooperate with its intent. The Secretary was further directed to send a copy of the resolution to Governor Robert B. Meyner; the President of the Medical-Surgical Plan of New Jersey; each member of the New Jersey State Legislature; and to the secretary of each county medical society.

R. N. CAGAN, M.D.
Reporter

Middlesex

A brief business meeting was presided over by Dr. John A. Smith, President, at Oak Hills Manor, Metuchen, on Wednesday, March 16.

On recommendation of the Judicial-Medical Ethics Committee, the following applications were accepted for presentation to the Credentials Committee of The Medical Society of New Jersey for election to membership by that Committee: Dr. Anthony M. Arangio, Fords, to Regular membership from two years' Associate membership—Sponsors: Norman Reitman and William Rubin, New Brunswick; to two years' Associate membership by transfer from the Mercer County Medical Society, Dr. Donald R. Reisfield, New Brunswick—Sponsors: Drs. Morton S. Brody and Irving E. Rineberg; to Regular membership by transfer from the Queens County Medical Society, New York, Dr. Sheldon G. Leibow, Perth Amboy—Sponsors: Drs. S. G. Berkow and S. Silverman.

The membership was informed by the Welfare Committee that decals for M.D.'s cars will be issued soon, free of charge, by The Medical Society of New Jersey.

A convivial evening then followed with the Middlesex County Pharmaceutical Association. The

hors d'oeuvres, cocktails and entertainment were enjoyed by all.

THOMAS I. STEINBERG, M.D.
Reporter

Passaic

The regular meeting of the *Passaic County Medical Society* was held on March 15 at 9:00 p.m. at the Casino in Clifton. Dr. Julian Cohen, President, called the meeting to order.

The President read the names of applicants for membership, and the following were elected: Active by transfer—Ernestine Sokal of Passaic; Associate members—Vincent J. Del Guidice, Paterson and Jane A. Colfax, Wayne.

The list of nominees for election as Delegates and Alternates to the Annual Meeting of The Medical Society of New Jersey in May was presented. The following members were unanimously elected for a three-year term (1960 through 1962).

Delegates
- Ben W. Berner, M.D.
- David I. Canavan, M.D.
- Otto Eisert, M.D.
- Paul B. Ferrary, M.D.
- Irving R. Hayman, M.D.
- Gordon W. Howe, M.D.
- Dorothy K. Klughaupt, M.D.
- David B. Levine, M.D.
- H. E. Reading, M.D.
- Leopold E. Thron, M.D.
- Wolfgang Vogel, M.D.

Alternates
- Peter G. Berkhout, M.D.
- Frank Brogan, M.D.
- H. Louis Chodosh, M.D.
- Samuel R. Reich, M.D.
- James R. Lomauro, M.D.
- Max Magnes, M.D.
- Andrew F. McBride, Jr., M.D.
- James P. Morrill, M.D.
- A. John Reinhorn, M.D.
- Christopher T. Reilly, M.D.
- Ralph C. Yeaw, M.D.

Nominating Delegate—Joseph E. Mott, M.D.
Nominating Alternate—Joseph R. Jehl, M.D.

A report was read from Dr. A. Hobson Davis, Chairman of the Hospital Relationship Committee, regarding the continuing shortage of interns in view of the requirements laid down by the American Medical Association on accepting interns from foreign schools. After considerable discussion, the following resolution was adopted for presentation to the 1960 House of Delegates.

Whereas, there has been a continuing shortage of interns in the United States, and

Whereas, many hospitals have been unable to secure their full quotas of interns with resultant deterioration of their training programs and in patient care, therefore,

Be It Resolved: (1) That the grade for standard certification by the Educational Council for Foreign Medical Graduates be reduced for the present,

(2) That the deadline for acceptance be extended, thus giving the hospitals more time for adjustment, and

Be It Further Resolved: That this resolution be forwarded to The Medical Society of New Jersey and that it be considered by the 1960 House of Delegates, and that an informational copy be sent to each component society in advance of the Annual Meeting of The Medical Society of New Jersey.

The President introduced Dr. Edward Edlkraut, who stated that this meeting was our Annual Lecture in Surgery in memory of Dr. Albert Hoheb. Dr. Edlkraut then turned the meeting over to Dr. Bernard Pinck, Program Chairman, who presented the guest speaker Arthur S. Localio, M.D., Professor of Clinical Surgery, New York Univ. College of Medicine. Dr. Localio spoke on "Inflammatory Diseases of the Intestines and Colon."

A sumptuous buffet supper was served to the 100 members attending the meeting, with the Passaic General Hospital as hosts.

IRVING CHRISMAN, M.D.
Reporter

Salem

The Elmer Community Hospital was host to the *Salem County Medical Society* at its regular meeting on Friday, March 18.

Dr. Joseph I. Echikson, founder of the Essex County Chapter of the American Cancer Society, spoke on *Chemotherapy in Cancer.* Dr. Echikson defined cancer as an uncontrolled growth of cells in tissues of the body. He outlined the types of cancer and the treatment available. The search for the cause of cancer continues throughout all sections of the country. It is hoped to pinpoint the presence of cancer in the body through the use of chemicals and it is felt that the future is favorable for a breakthrough in treatment to help eliminate the need for surgery and x-ray therapy.

Following Dr. Echikson's discussion, Dr. George A. Nitshe, Elmer, President of the Medical Society, presented a blood pressure cuff to the hospital. Mr. Herbert Lowe, member of the Board of Directors, accepted the gift on behalf of the hospital staff.

Members of the society then adjourned to the dining room where a delicious turkey dinner was enjoyed by all.

G. F. REICHWEIN, M.D.
Reporter

Book Reviews

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Therapeutic Radiology. By William T. Moss, M.D. St. Louis, 1959. Mosby. Pp. 403. ($12.50)

Under each organ system, Dr. Moss presents a vivid discussion of the rationale of radiation therapy, including dosage determination, conventional x-ray therapy, supervoltage, cobalt teletherapy, and radium therapy, the limitations of therapy, the technic and principles of planning, and therapeutic response. A very valuable feature of the book is a discussion of the response of normal tissue to radiation in each organ.

Each chapter presents a precise description of the clinical problem, the pathology, and the radiotherapeutic principles pertinent to the area. The illustrations clearly depict the clinical and pathologic aspects of the diseases; but more illustrations of the therapy portals and cross-sections of therapy plan would be helpful.

The discussion of x-ray therapy of arthritis, including ankylosing spondylitis, and bursitis is too brief. There is no discussion of radiotherapy of carcinoma of the vulva, vagina, or fallopian tubes. While the latter might be excluded because of rarity, the former two diseases are usually included in books like this. Otherwise this text is recommended for its practical and modern approach to radiation therapy.

JULES H. BROMBERG, M.D.

The Life and Times of Sir Charles Hastings, Founder of the British Medical Association. By William H. McMenemey, M.D. Baltimore, 1959. The Williams & Wilkins Co. Pp. 516. ($10.00)

Sir Charles Hastings (1794-1866), Founder of the British Medical Association, lived in spirited times and contributed a hero's share to the unification of the British medical profession. His leadership, and the contributions of his colleagues, led to the Medical Act of 1858—the Magna Carta of British medicine.

The British Medical Association was founded on July 19, 1832 by provincial medical practitioners who were being "snubbed" by the Royal Colleges. Twenty-five years later their efforts culminated in the Medical Act, which received Royal assent on August 4, 1858. From this sanction came a great medical corporation that today provides a professional and scientific forum for all categories of physicians.

Dr. McMenemey, a psychiatrist, has written a human and scholarly account of Sir Charles and his colleagues. A paucity of detail about the life of Charles Hastings is compensated by a broad review of his times. Son of a rural clergyman, he received his medical degree at Edinburgh in 1818 and returned to Worcester where he became active as practitioner, health officer, citizen and naturalist. His professional accomplishments, recognized by knighthood in 1850, were valuable and of lasting importance. Professional arguments, debates, personalities and problems of the 19th century in England come to life as one follows Hastings through a dynamic period in medicine and surgery. From such trials in the past came notable achievements of benefit today.

A bibliography of the writings of Sir Charles Hastings, from 1817 to 1866, appends this biography. Well-illustrated, it also has a complete general bibliography. The book is recommended for all interested in the evolution of modern medicine.

FRED B. ROGERS, M.D.

Physiology of the Eye. Francis H. Adler, M.D. St. Louis, 1959. Mosby. Pp. 788 with 372 illustrations. Ed. 3. ($16.00)

The third edition of Dr. Adler's review of ocular physiology brings up to date a classic in ocular literature. In this latest edition, the author has revised most of the chapters, and new illustrations have been included.

In view of the increased importance of electrophysiology in all of medicine, and in ophthalmology in particular, it is good to see the expanded discussions of these aspects of ophthalmology in this 1959 edition. In particular, electromyography has received considerable impetus during the past years, and Dr. Adler's discussion of ocular motility includes some of Dr. Breinin's excellent work, as well as many of his illustrations.

The revision of the chapter on intraocular pressure has an expanded section on tonography, and a new section on pathologic physiology of glaucoma. In entoptic phenomena, new work has been added. Dr. Adler's chapter on entoptic and allied phenomena contains information on Moore's lightning streaks, the phosphene of quick eye motion, and the intriguing phenomenon of Haidinger's brushes. The chapter on binocular vision is con-

siderably revised with much additional information such as the section on the horopter. In addition, many new illustrations are noted.

This edition has been revised and expanded in every way. The book is longer, and has more illustrations than the previous edition. New material published in the last few years has been included, and many of the illustrations have been revised, and sections rewritten to produce greater clarity, and to conform with current theory.

This latest edition of Dr. Adler's book confirms that *Physiology of the Eye* will continue to be a standard work for students of ophthalmology.

FLOYD H. FARRANT, M.D.

Observations on "Direct Analysis." Morris W. Brody, M.D. New York, 1959. Vantage Press. Pp. 104. ($2.95)

Suppose that the following bits of conversation were reported to you, where would you suppose them to have been uttered, and by whom? "I will knock you through that wall in a minute. You are ready to have intercourse now." (page 63). "You are still crazy. I am your God." (page 56). "I will . . . be your mother and father. I love you, but your mother can't stand the sight of you. You are goofy." (page 32). "I will kill you if you hear the voices." (page 79). "You want to f--- your mother." (page 55). "Can you be insane for half an hour?" (page 35).

Anyone would correctly diagnose the environment to be that of psychotics. What is a little harder to guess, is that the words are spoken by the therapist, Dr. John N. Rosen, who developed a special approach for the treatment of psychotics. The reporter is Dr. Brody, the author of the book. The examples cited were taken from verbatim reports of conversations between Dr. Rosen and his patients.

The "psychotic" character of Dr. Rosen's words is not fortuitous. The idea behind this approach is for the therapist to communicate "directly" with the unconscious of the patients, on their own level of feeling and verbalization. One aim is to induce guilt, shame, and dissatisfaction with the psychotic framework. The reason for the outrageous frankness and the confrontation of the patient with his incestuous wishes, is to build up tolerances with regard to the impulses the suppression of which might have driven the patient into psychosis. Thus, while there is obviously madness in Dr. Rosen's method, there is also considerable method in this madness.

Although psycho-analytic insights are used, the technic of confronting the patient with intuitive insights of the therapist has nothing to do with orthodox psychoanalysis as practiced by Freudians or related schools. (Dr. Rosen would answer, I surmise, that this only demonstrates how unimaginatively the psychoanalysts use the insights of psychoanalysis.) The confrontations of the patient with the intuitive interpretations of the therapist can hardly be expected to produce insight, particularly since Dr. Rosen seems insensitive to the patient's reactions to the confrontations. This is very convincingly described by Dr. Brody, a practicing psychoanalyst, who does not by any means subscribe to Dr. Rosen's technics. Whatever therapeutic successes are observable must stem from the inspirational and exhortative aspects of the method.

How successful is Dr. Rosen? Apart from the difficulty of appraising "success" (and differential success as compared to other technics), Dr. Brody's book does not tell. This is part of a cooperative venture in which others will try to measure success. Dr. Brody attempts to evaluate the character of, and the emotional dynamics involved in the unorthodox approach of Dr. Rosen. This he does interestingly, instructively and with as many substantive discoveries as one might perhaps expect when geologists and archeologists visit sites of work-blasts in the hope of finding something new.

THEA BRY

Instructional Course Lectures for 1959: American Academy of Orthopaedic Surgeons. St. Louis, 1959. Mosby. Pp. 332. ($16.00)

As in the past, the publication of this sixteenth set of the Lectures of the American Academy of Orthopedic Surgery has been eagerly awaited by all students of the subject. A brilliant and distinguished group of authors have written articles which are explicit, concise and well supplemented by clear illustrations and photographs.

Part One is a symposium on athletic injuries including prevention, diagnosis and treatment as well as rehabilitation of the injured athlete. This subject is an innovation of the course which should be of interest to general practitioners as well as surgeons.

Part Two consists of lectures on the hand, including an instructive chapter devoted to its anatomy, which is beautifully illustrated by photographs of freshly dissected specimens.

Part Three deals with foot problems commonly seen by the orthopedist including current trends in the treatment of clubfeet and valgus deformities.

Part Four is a symposium on the injuries and internal derangements of the knee usually seen in general practice.

The fifth part of this volume deals with injuries and deformities of the spine including the rehabilitation of the industrial "low back cripple" and the principles and treatment of scoliosis.

Parts Six and Seven cover other timely orthopedic subjects such as unequal extremities, electromyography and the use of the hip prostheses in the treatment of intracapsular fractures of the femoral neck.

This volume is particularly useful to the orthopedist as an excellent but incomplete "refresher course." To the general surgeon and general prac-

titioner the discussions dealing with the treatment of athletic, industrial and geriatric trauma will prove to be current and enlightening guides.

M. A. Paoletti, M.D.

Cancer in Families. Douglas P. Murphy, M.D. and Helen Abbey, Sc. D. Harvard University Press, Cambridge, Mass. 1959. Pp. 76. ($2.50)

Any contribution to our knowledge of cancer is welcome. Here is a study of 200 families in which one or more members suffered from cancer of the breast. The authors were unable to find any statistically reliable evidence of a familial factor. This should certainly be reasurring to relatives of cancer patients, and the study is a solid and sober one. The authors use the clinically unfamiliar word *proband* for an individual in whose family there was a malignancy. The book has no index. These, however, are trivial faults in this otherwise substantial piece of scholarship.

Victor Huberman, M.D.

Research on Novocaine® Therapy in Old Age. Anna Aslan, M.D. and co-workers. Consultants Bureau. 227 W. 17 Street, New York City. Paper. 1959. Pp. 71. ($12.50)

It is reported that there was regression in the evidences of senility when patients are given intramuscular injections of procaine (2 per cent solution) in 5 cubic centimeter amounts three times a week. Mental and physical evidences of cerebral arteriosclerosis are said to be improved. This 71-page paper-bound pamphlet sells for $12.50. It is a translation of seven papers published in *Die Therapiewoche* in 1956 and 1957.

Henry A. Davidson, M.D.

Manual of Skin Diseases. By G. C. Sauer, M.D. Philadelphia, 1959. Lippincott. Pp. 269 with 151 illustrations (28 of them in color). ($9.75)

As a sort of emergency manual for non-dermatologists this is an excellent, concise, lavishly illustrated text. Dr. Sauer does not take much space for bibliographies, theories, or histopathology. Each of the common lesions is discussed in traditional fashion: visible lesions, distribution, course, cause, contagiousness, diagnosis, treatment. As a dividend, the book provides the following features: a chapter on the skin and internal diseases; geographical distribution of various skin disorders; list of basic equipment needed for diagnosis and treatment of skin lesions; a combination index and dictionary; and, in the end papers, charts of the human body showing locations of common skin diseases. The material on treatment is simple, practical, and told in an informal way as if Dr. Sauer were looking over your shoulder. Altogether, a handy volume for any practitioner who has ever had or seen a skin disorder.

Hildegarde Maricq, M.D.

Physical Diagnosis, The History and Examination of the Patient. By John A. Prior, M.D. and Jack S. Silberstein, M.D. St. Louis, 1959, Mosby. Pp. 363 with 193 illustrations. ($7.50)

This book is meant as a text for medical students. The authors, because they teach medicine, realize the importance of instructing the student in the fundamentals of obtaining a good history and a satisfactory physical examination. To give him an unshakable basis in the use of "the tools of his trade" is their purpose. They believe that the novice's future in the profession is thus determined.

Accordingly, they have planned their volume and purposely omitted many non-essential items which would be found in standard texts of the subject. This omission includes such things as historical background, the use of eponyms and seldom used or more advanced procedures.

Discussion of disease has been held to a minimum. It is thought most important to teach the student an appreciation of the normal. Yet the meaning of medical terms and symptoms is clearly explained and their importance emphasized. Important points of differential diagnosis are noted.

The result is a concise volume giving clear-cut explanations of the subject matter. A good deal of space and effort are expended in the technic of history taking. Demonstration is made also of faulty methods and their correction to bring out the necessity of the proper approach. This is followed by separate chapters devoted to the different organ systems which are handled with the same clarity and effect. A separate chapter on the pediatric examination is also included.

The general excellence of this work is greatly enhanced by the many fine photographs which complement the text in fine detail. These photos are some of the best to be seen in any medical text.

Although intended primarily for the beginner, this volume is an excellent reference book on physical diagnosis for any practitioner's library. By their singleness of purpose, the authors have reminded us of something which we should not have forgotten, that, "Methods are the Masters of Masters."

John F. Vining, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

MAY, 1960 • VOL. XXXIII. No 5

RECOMMENDATIONS OF THE ARDEN HOUSE CONFERENCE ON TUBERCULOSIS

The United States Public Health Service and the National Tuberculosis Association asked a group of national leaders in public health and tuberculosis control to meet at Arden House in order to define the major gaps in present practices in tuberculosis control and to suggest needed action.

The major recommendation of the Conference is a program for wide-spread application of chemotherapy as a public health measure for the elimination of tuberculosis in the United States:

Goal: To sterilize that important part of the reservoir of tubercle bacilli that presently exists throughout the country in persons currently suffering from active tuberculous disease, whether presently known or unknown to public health authorities, and in selected persons who previously have had active disease and were inadequately treated.

Technique: Mobilize all resources for a wide-spread application of the scientifically demonstrated and medically accepted procedures of adequate chemotherapy. These include the proper dosage of appropriate drugs or combination of drugs given continuously over an adequate period of time—procedures that are known to destroy tubercle bacilli in the human body, render the patient's disease noncommunicable to others, and minimize the possibility of reactivation.

The unique aspect of this recommendation lies in its emphasis on such chemotherapy primarily *as a public health tuberculosis control measure* (as well as for the benefit of the individual patient) with all of the connotations of community mobilization and control by public health authorities that this new concept implies. This recommendation obviously implies as well an adequate case-detection program.

In addition, the Conference considered some of the deficiencies of current tuberculosis control programs. With regard to strengthening these programs it made the following recommendations without designating priorities:

1. Assumption by state and local public health authorities of their responsibility for ensuring adequate treatment and rehabilitation of all patients with tuberculosis. Regardless of the place of treatment of the patient, the attending physician should have available to him expert consultation in the fields of both the medical sciences and the social services, which should be integrated in such a manner as to provide continuity of care until the patient is restored to maximum possible productivity.

2. Concentration of the tuberculosis control program on those segments of the population with the greatest tuberculosis problem. This would include re-examination of tuberculosis control grants to states by the Federal government in recognition of the fact that there are strongholds of tuberculosis in the country that are in need of extra resources.

3. Establishment of intermediate goals, en route to the elimination of tuberculosis, together with corresponding suggested program priorities and performance standards, in accordance with a suggested outline to be prepared by the U. S. Public Health Service in cooperation with the National Tuberculosis Association. In formulating such goals and standards the state health

A Report of the Arden House Conference on Tuberculosis, National Tuberculosis Association, *Bulletin, February, 1960.*

department should consult with its state tuberculosis association to develop a unified joint program of tuberculosis control for that state, taking into consideration the needs, extent of the problem, and resources of the various areas within the state. These state program blueprints should be made available to the U. S. Public Health Service and the National Tuberculosis Association to assist them in maintaining realistic national goals and standards.

All such goals, program priorities, and performance standards should be reviewed and revised periodically to take cognizance of changing conditions and new knowledge.

4. Periodic evaluation on a state-wide basis of tuberculosis detection programs, with adjustment of such programs accordingly, so as to obtain maximum results from the funds available. The U. S. Public Health Service should provide assistance in such a study to any state that does not have the resources to conduct its own. The U. S. Public Health Service in cooperation with the National Tuberculosis Association should formulate and make available a guide for the conduct of such state-wide evaluation of tuberculosis detection programs.

5. Periodic review by the U. S. Public Health Service of reporting practices within the various states in order to promote greater uniformity and to permit interpretation of comparable case report data.

6. Systematic local investigation of tuberculosis cases first reported by death certificate to be conducted by appropriate representatives of the local medical community.

7. Provision of laboratory services conveniently available to all physicians diagnosing and treating tuberculous patients. These services should meet certain minimum standards, such as:

a) provision for the detection by culture and the identification of *Mycobacterium tuberculosis* and other strains of mycobacteria; and

b) provision for performing tests of bacterial susceptibility to the antimicrobial agents most commonly used in the treatment of tuberculosis.

The Conference also recommended that there be regularly recurring evaluation of the adequacy and accuracy of such laboratory services.

8. Use of BCG according to the recommendations made by the Ad Hoc Advisory Committee on BCG to the Surgeon General of the U. S. Public Health Service (*American Review of Tuberculosis and Pulmonary Diseases*, Vol. 76, No. 5, November 1957) and by the American Trudeau Society (*Ibid.*, Vol 78, No. 1, July 1958). The Conference further recommended that there be established improved standards for the evaluation of activity of BCG vaccines.

9. Intensification of research with regard to the social, psychological, and cultural factors that affect:

a) acceptance of case detection and treatment, together with continuation of treatment;

b) differential susceptibility of the individual to tuberculosis; and

c) nature and results of treatment programs.

This research would attempt to clarify what the social components are in the etiology of tuberculosis and in the program of tuberculosis control. The latter, in turn, would be concerned with the cultural and other social aspects of the population involved in the particular control program under consideration and with the social aspects of the manner in which the program is conducted (for example, how it deals with the so-called "recalcitrant" patient).

10. Intensification of research for a simple and accurate tuberculin test that can be applied and read by nonmedical personnel.

11. Recognition of the importance and potential significance of the current isoniazid prophylaxis field study of the Tuberculosis Program of the U. S. Public Health Service. The Conference recommended that adequate appropriations be continued by Congress for support until completion of this study, which may provide a significant shortcut to elimination of tuberculosis in this country.

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Myositis	Postoperative muscle spasm	Angina pectoris
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References: 1. Lichtman, A. L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958. 2. Mullin, W. G., and Epifano, Leonard: Am. Pract. & Digest Treat. 10:1743, Oct., 1959. 3. Gruenberg, Friedrich: Current Therap. Res. 2:1, Jan., 1960. 4. Shanaphy, J. F.: Current Therap. Res. 1:59, Oct., 1959. 5. Ganz, S. E.: J. Indiana M. A. 52:1134, July, 1959. 6. Stough, A. R.: J. Oklahoma M. A. 52:575, Sept., 1959.

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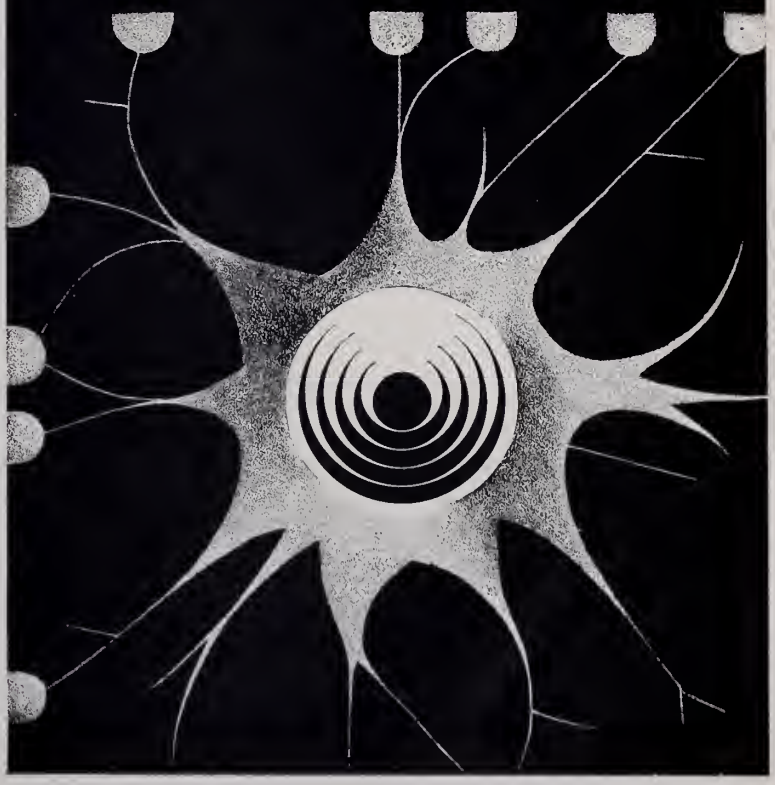
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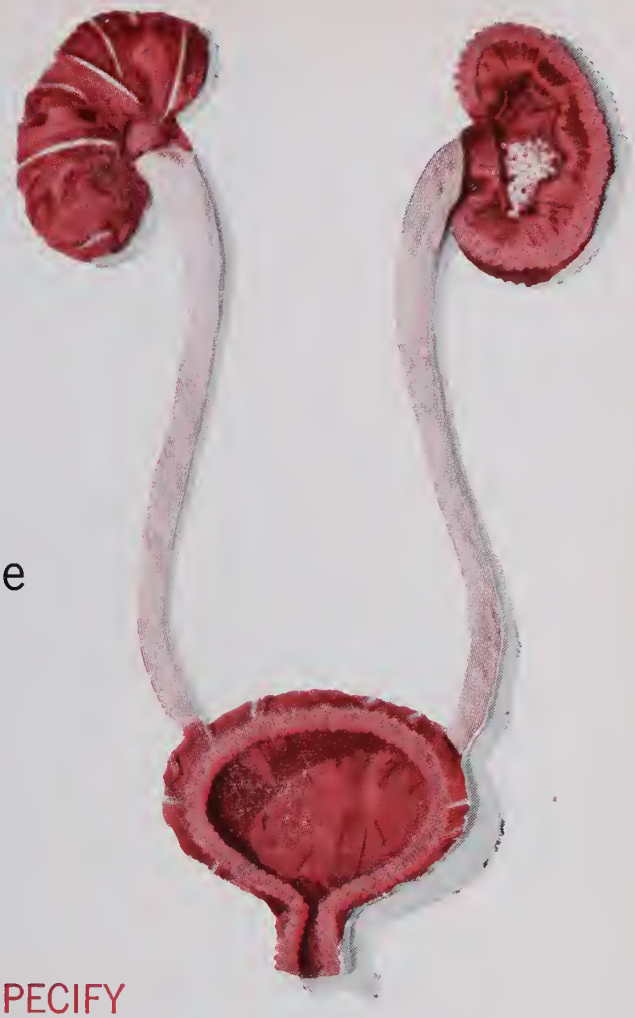
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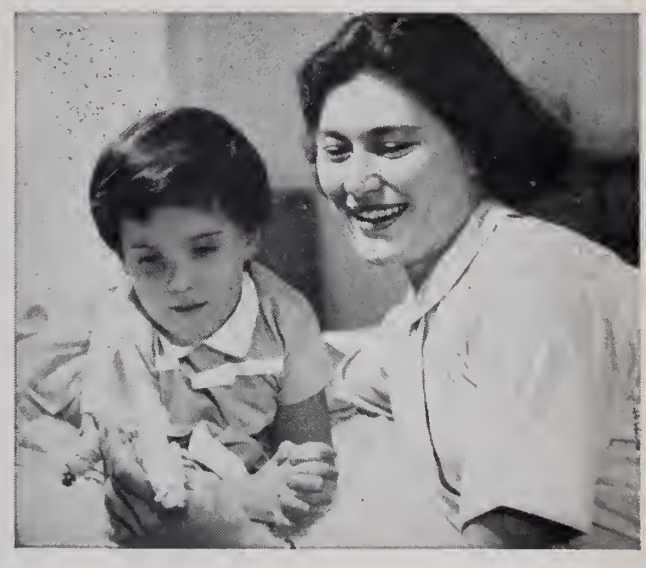
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Alexander, L. (35 patients): Chemotherapy of depression—Use of meprobamate combined with benactyzine(2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A.166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Deprol as adjunctive therapy for patients with advanced cancer. Antibiotic Med.& Clin. Therapy. In press, 1959. Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System **20**:263, June 1959. **4.** Breitner, C. (1 patients): On mental depressions. Dis. Nerv. System **20**:142, (Section Two), May 1959. **5.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Benefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression—New technics and therapy. Am. Pract. & Digest Treat. **10**:1525, Sept. 1959. **6.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **7.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System **20**:364, (Section One), Aug. 1959. **8.** Ruchwarger, A. (7 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia **28**:438, Aug. 1959. **9.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy. In press, 1959. **10.** Splitter, S. R. (84 patients): The care of the anxious and the depressed. Submitted for publication, 1959.

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Laughlin, H. P.: The Neuroses in Clinical Practice, Saunders, Philadelphia, 1956, pp. 448-481.



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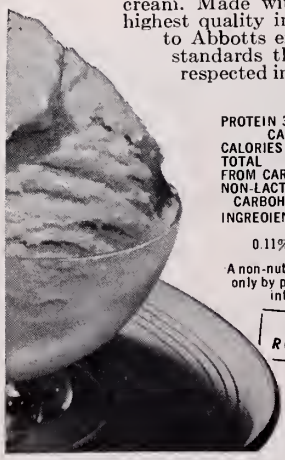


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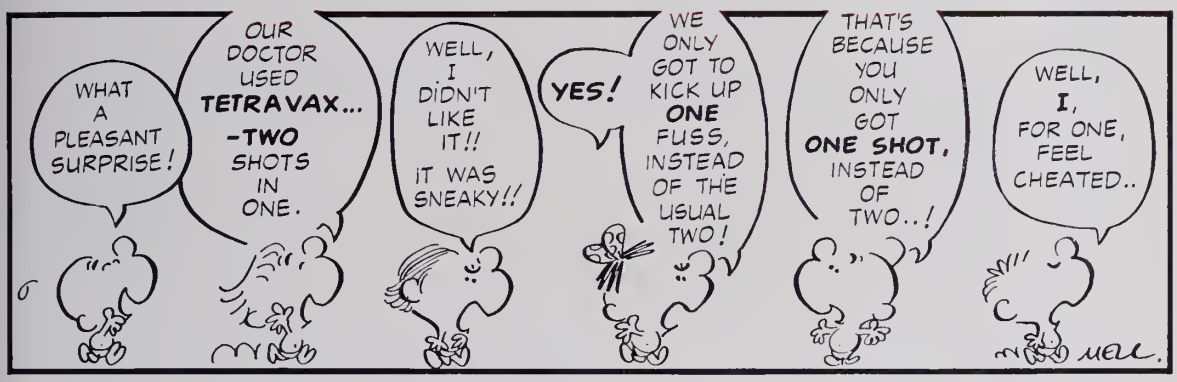
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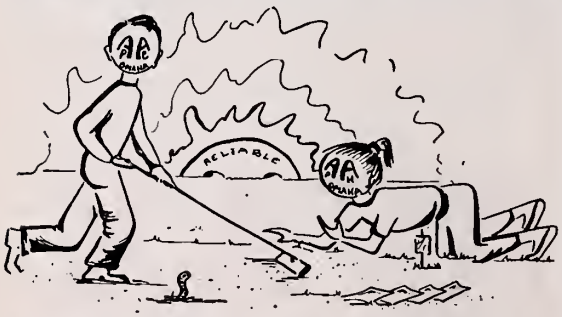
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"DBI has been able to replace insulin or other hypoglycemic agents with desirable regulation of the diabetes when it is used in conjunction with diet in the management of adult and otherwise stable diabetes."[3]

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Among those diabetics who responded to tolbutamide initially and became secondary failures **DBI "gave a satisfactory response in 55%."**[4]

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Send for brochure with complete dosage instructions for each class of diabetes, and other pertinent information.

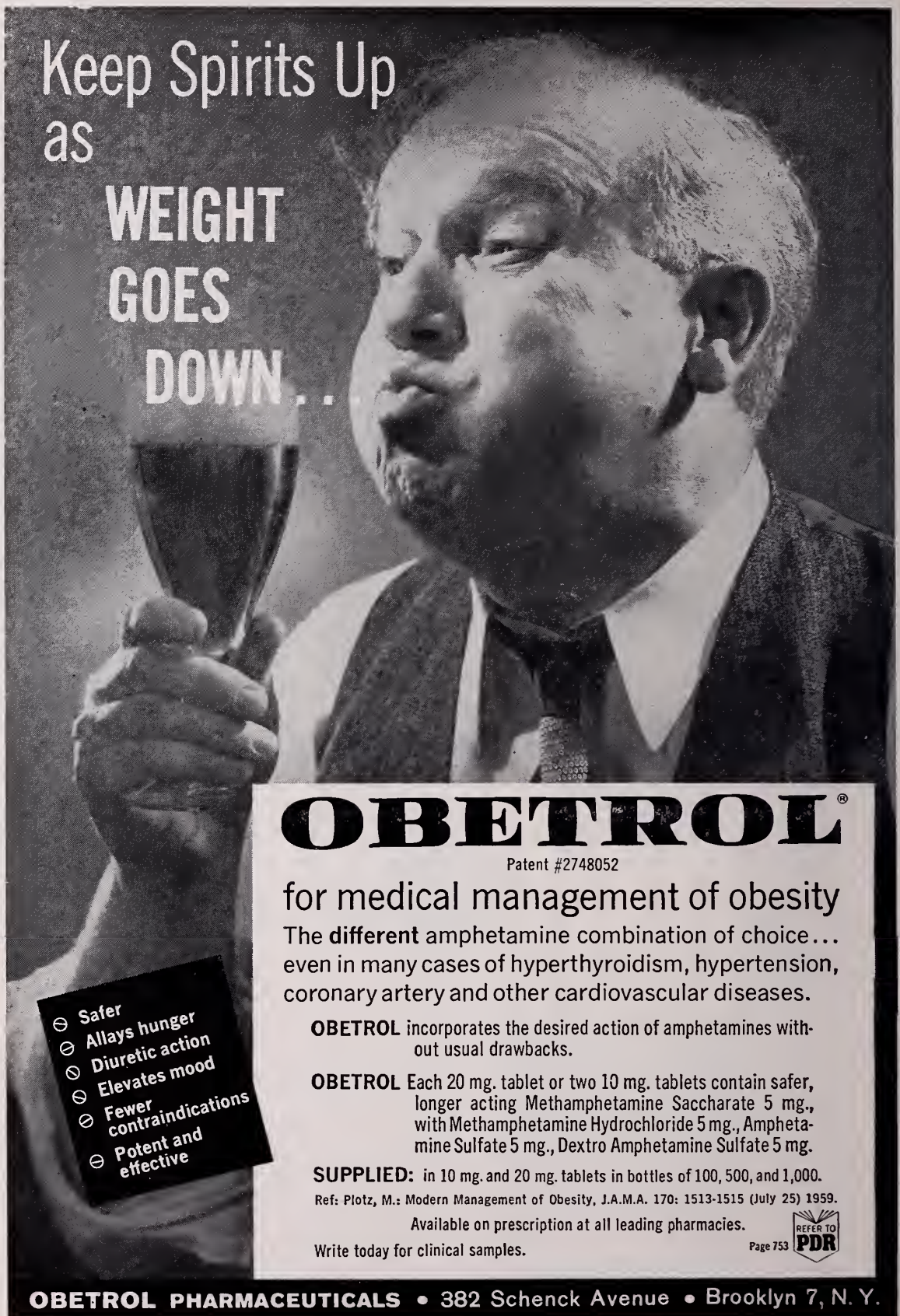
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Ref: Plotz, M.: Modern Management of Obesity, J.A.M.A. 170: 1513-1515 (July 25) 1959.
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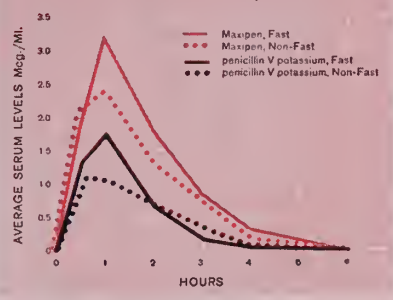
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References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

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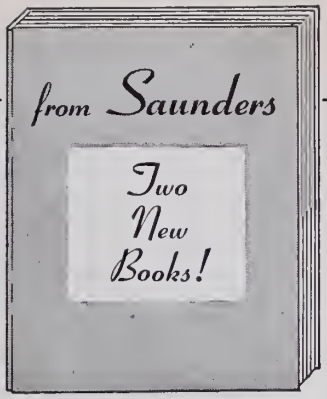
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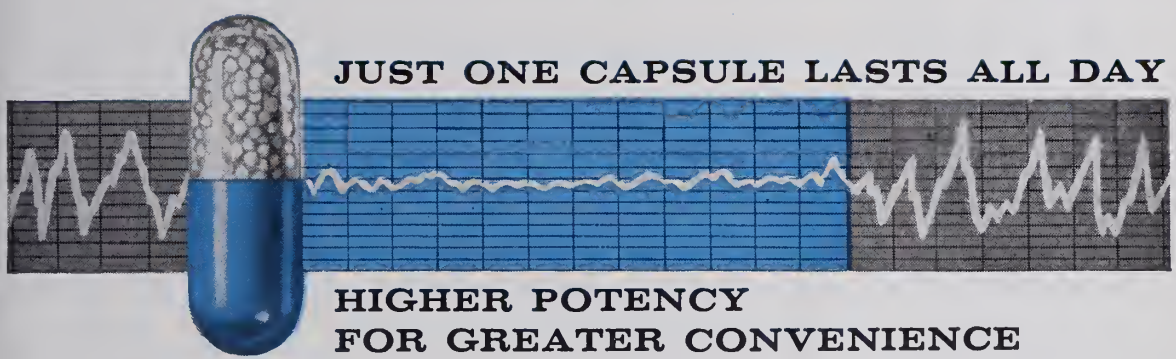
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control the tension—treat the trauma



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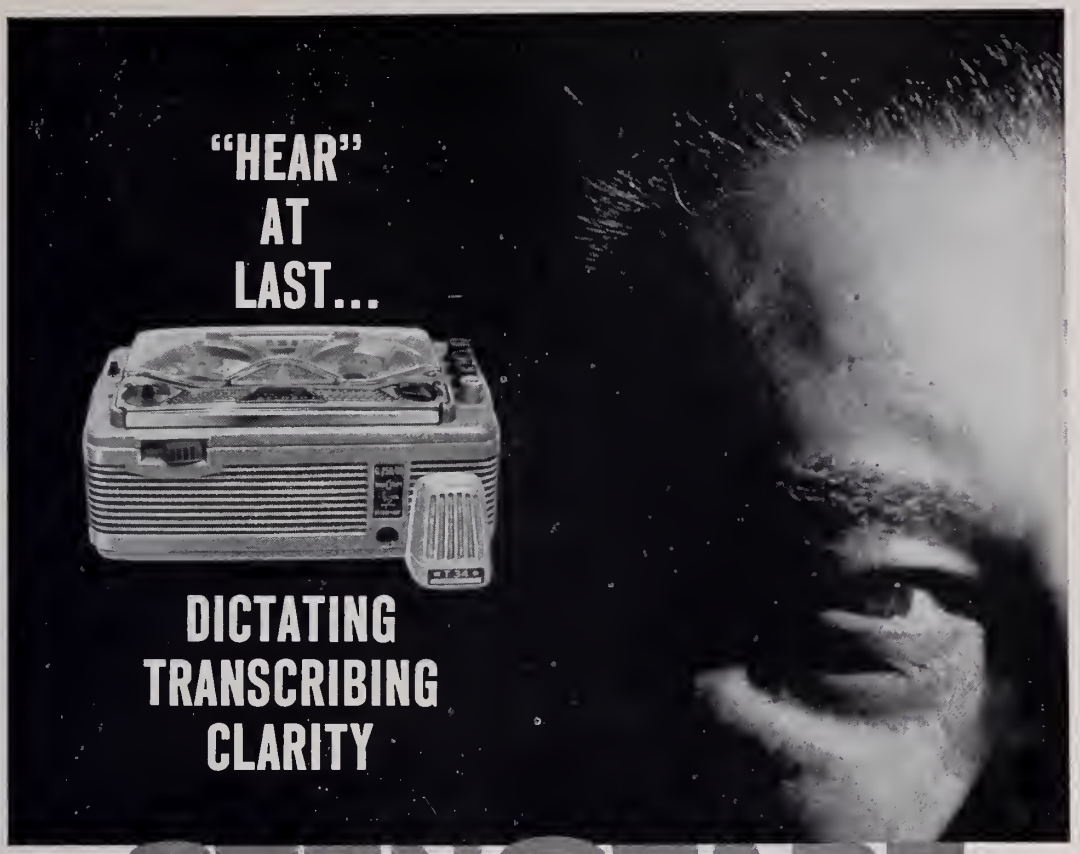


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now...there is a way to prompt, dependable relief of back distress

the pain goes while *the muscle relaxes*

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new chemically improved penicillin which provides the highest blood levels that are obtainable with oral penicillin therapy



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Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

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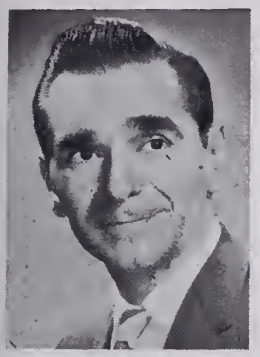
*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

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How Doctors Can Profit From Investments in Giant Real Estate!



by Mortimer L. Schultz, Chairman of Board, Office Buildings of America, Inc., Newark, New Jersey

Mr. Schultz has talked on real estate syndication before hundreds of college, medical, executive and real estate groups throughout the Northeast. The questions presented below are representative of those most often asked by doctors' investment groups and from inquiries received from doctors.

Q What is a Real Estate Syndicate?

A A group of investors who will purchase one particular property together. This property being of a size beyond the means and desire of any one alone.

Q What are current yields and how are they paid?

A Yields currently range from 7 to 14% and because of the nature of real estate syndicates, cash distributions are paid monthly.

Q How can syndicates benefit a doctor?

A Subject to the risks inherent in real estate, participation in syndicates can convert ordinary income into long term capital gain type of income and lessen the investors' tax burden.

Q Show an example of how ordinary income converts to long term capital gains.

A A doctor holding a $110,000 investment in Building Realty Company received $10,450 cash income during 1959. None of this was subject to ordinary income tax and in addition he was permitted to write off an additional $4,700 of income received from his practice due to the depreciation reserves on the particular building.

Q What is the liability of an investing partner?

A A limited partner risks his investment only, and this investment may range from $2,500 up depending on the cost of a unit of participation.

Q Are partnership interests marketable?

A At a price, a willing seller can always find a willing buyer, thus partnership interests are marketable. Many investment firms, such as First Jersey Securities Corporation, have created a secondary market for the resale of syndication units.

Q Who is the typical syndicate investor and how much has been invested in syndicates to date?

A A survey recently taken shows the typical investor to be (a) in his forties or fifties, (b) an executive or professional man with an income of $10,000 to $50,000 and (c) with $5,000 to $35,000 invested in two or more syndicates. Syndicate investments throughout the country are currently at a rate of three billion dollars annually.

Q What is Office Buildings of America, Inc.?

A Office Buildings of America is a realty investment corporation that owns interests in or operates, 30 office buildings and plants throughout the USA. In addition, it is concerned with new construction, lease-backs, mortgage financing, estate planning and the sale of mutual funds. A number of its principals are among the pioneers in real estate syndication.

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Recent JAMA editorial statement clarifies the current controversy about dietary fats

Excerpted from the March 12, 1960, issue of The Journal of The American Medical Association:

"It is accepted generally that specific alteration in the diet will lower the concentration of cholesterol in the blood. The most effective results to date have been achieved by increasing consumption of polyunsaturated fatty acids, particularly linoleic acid. However, indefinitive and conflicting information has left much to the imagination of some food processors. Some of the largest vegetable oil processors in the United States have implied in advertisements that the cholesterol level can be lowered merely by adding polyunsaturated fatty acids to the diet. This selling campaign has created confusion among lay people, making it increasingly important that the physician clarify for his patients the conditions under which changes in the diet will be effective.

The patient should understand that if he increases his consumption of polyunsaturated fatty acids without reducing his intake of other fats, little is gained save for additional calories which could lead to obesity. A particular regimen will be effective only if polyunsaturated fatty acids are responsible for an appreciable percentage of the total fat calories. That is, they must replace rather than supplement some of the saturated fats and oils already in the diet.

* * *

Some manufacturers cite the "iodine number" of a fat or oil as evidence of the unsaturated fatty acid content of their product. This number is not a reliable indicator of therapeutic value because it measures monounsaturated and polyunsaturated fatty-acid content at the same time. A monounsaturated acid, like oleic, takes up two iodine atoms but does not affect the cholesterol concentration of the blood. A polyunsaturated acid, like linoleic, takes up four iodine atoms. In a product containing large amounts of oleic acid and small amounts of linoleic acid, the iodine number is nearly the same as it would be for a product containing little oleic acid and a modest amount of linoleic acid. Cottonseed oil has an iodine number of 110 and corn oil a number of 127; yet they each have about the same amount of linoleic acid.

* * *

Low-fat diets will not reduce the concentration of circulating cholesterol and lipoproteins as effectively as will diets containing an adequate percentage of polyunsaturated fatty acids. Weight-reduction regimens are basically low in fat, and if a lowered cholesterol level is necessary, planning must be done to maintain the proper ratio of saturated to unsaturated fats."

* * *

Herbert Pollack, M.D.
Associate Professor of Clinical Medicine
Postgraduate Medical School
New York University, New York

Where a vegetable (salad) oil is medically recommended for a cholesterol depressant reg



Lean Beef Tips Veronique an example
of glorious eating from Wesson

sson is unsurpassed by any readily available brand

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Wesson is 100% cottonseed oil–winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
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Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

Each pint of Wesson contains 437-524 Int. Units of Vitamin E

FREE Wesson recipes, available in quantity for your patients, show how to prepare meats, seafoods, vegetables, salads and desserts with poly-unsaturated vegetable oil. Request quantity needed from The Wesson People, Dept. N, 210 Baronne St., New Orleans 12, La.

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IMPROVED ANTIBIOTIC ACTION FROM ISOMERIC COMPLEMENTARITY

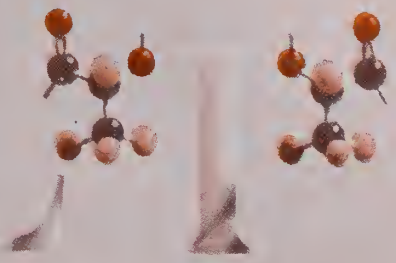
SUPPLY: SYNCILLIN TABLETS–250 mg. and SYNCILLIN TABLETS–125 mg.
SYNCILLIN FOR ORAL SOLUTION–60 ml. bottles–when reconstituted, 125 mg. per 5 ml.
SYNCILLIN FOR PEDIATRIC DROPS–1.5 Gm. bottles. Calibrated dropper delivers 125 mg.





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ICILLIN™



potassium phenethicillin (POTASSIUM PENICILLIN-152)

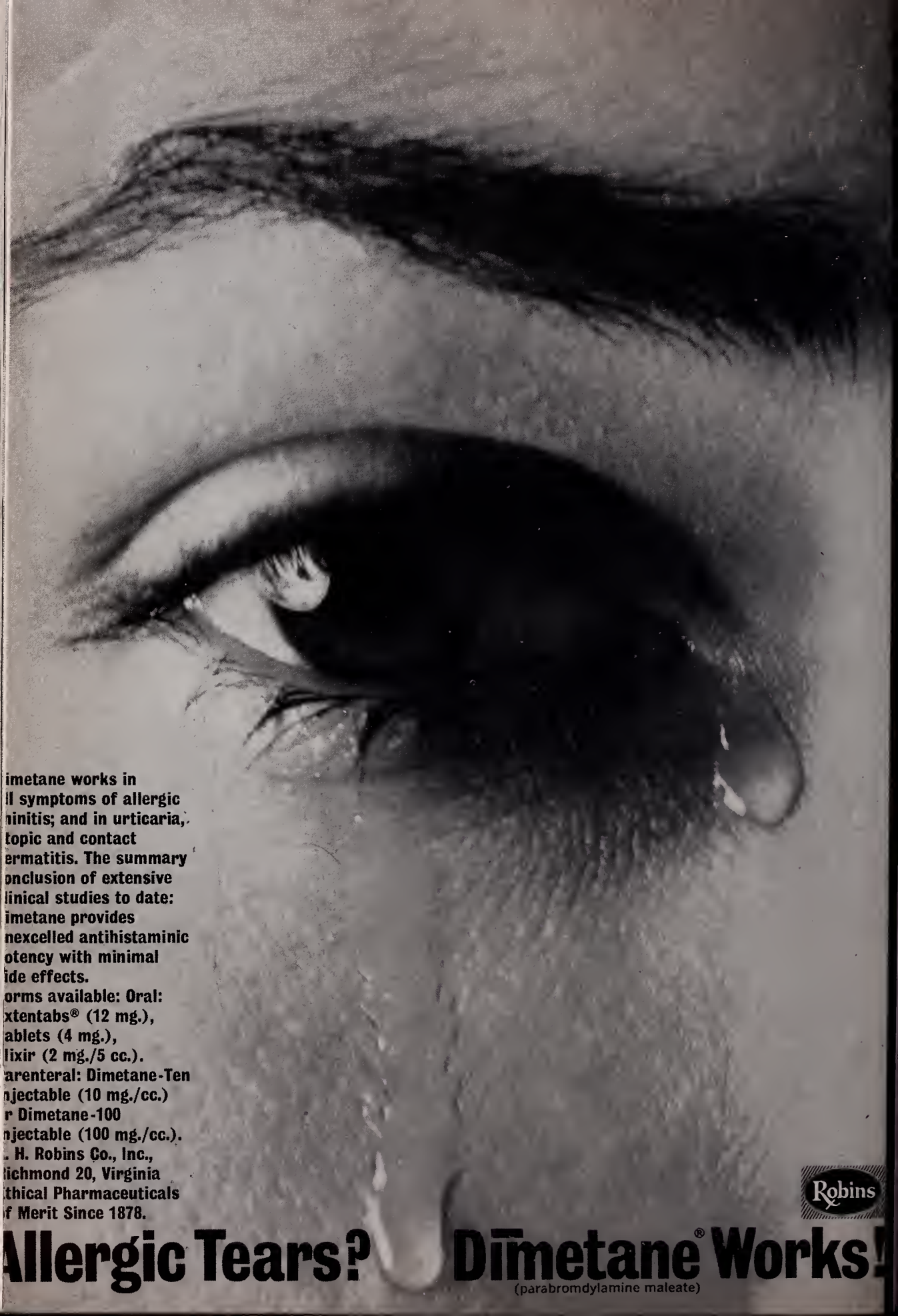
ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSE	*REDUCED RATE OF INACTIVATION BY STAPH PENICILLINASE*	*SOME STAPH STRAINS MORE SENSITIVE TO SYNCILLIN IN VITRO*

BRISTOL LABORATORIES, SYRACUSE, NEW YORK

BRISTOL







imetane works in
ll symptoms of allergic
ninitis; and in urticaria,
topic and contact
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imetane provides
nexcelled antihistaminic
otency with minimal
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orms available: Oral:
xtentabs® (12 mg.),
ablets (4 mg.),
lixir (2 mg./5 cc.).
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. H. Robins Co., Inc.,
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Robins

Allergic Tears? Dimetane® Works!

(parabromdylamine maleate)

Why Clinical Judgment Often Dictates Altafur for Peroral, Systemic Therapy of Pyodermas

Gratifying Therapeutic Response

ALTAFUR was found "highly satisfactory in most of the primary and secondary bacterial dermatoses treated to date," including "pyodermas . . . caused by antibiotic resistant strains of staphylococci."[1] In a nationwide survey[2] there were **94%** satisfactory results (cured or improved) among 159 patients treated with ALTAFUR for pyodermas.

Virtually Uniform in vitro Susceptibility of Staphylococcus aureus

99.5% of isolates (214 of 215) from patients with staphylococcal infections—including many antibiotic-resistant strains—proved sensitive in vitro to ALTAFUR in tests conducted across the nation.[3] **99.7%** of staphylococcal isolates (334 of 335) at a large general hospital—including many antibiotic-resistant strains—proved sensitive in vitro to ALTAFUR.[4]

Wide, Stable Antimicrobial Spectrum

"Because of its relationship to previously developed nitrofurans, it is anticipated that [ALTAFUR] will retain its original spectrum after longstanding clinical usage."[5] Development of significant bacterial resistance to ALTAFUR has not been encountered to date.[6]

Minimal Side Effects

Side effects are easily avoided or minimized by these simple precautions: 1) *alcohol should not be ingested in any form, medicinal or beverage, during* ALTAFUR *therapy and for one week thereafter* 2) each dose should be taken with or just after meals, and with food or milk at bedtime (to reduce the likelihood of occasional nausea and emesis).

---

1. Weiner, A. L.: Paper presented at the Conference on Recent Advances in the Treatment of Chronic Dermatoses, University of Cincinnati (Ohio), Nov. 5, 1959. 2. Compiled by the Medical Department, Eaton Laboratories, from case histories received. 3. Christenson, P. J., and Tracy, C. H.: Current Therapeutic Research 2:22, 1960. 4. Glas, W. W., and Britt, E. M.: Proceedings of the Detroit Symposium on Antibacterial Therapy, Michigan and Wayne County Academies of General Practice, Detroit, Sept. 12, 1959, p. 14. 5. Leming, B. H., Jr.: Ibid., p. 22. 6. Investigators' reports to the Medical Department, Eaton Laboratories.

Tablets of 250 mg. (adult)

and 50 mg. (pediatric)

bottles of 20 and 100

Altafur®

brand of furaltadone

NITROFURANS . . . a unique class of antimicrobials

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Recognizing that the exchange of ideas is fundamental to medical progress, Lederle continues its Symposium program with the 9th year of scheduled meetings. Through these Symposia, sponsored by medical organizations with our cooperation, over 50,000 physicians have had the opportunity to hear and question authorities on important advances in clinical medicine and surgery. You have a standing invitation to attend any of these Symposia with your wife, for whom a special program is planned.



ANCHORAGE, ALASKA
Saturday, June 11, 1960
The Westward Hotel

WEST POINT, NEW YORK
Thursday, Friday, Saturday,
June 16, 17, and 18, 1960
United States Thayer Hotel

***MADISON, WISCONSIN**
Thursday, June 23, 1960
The Holiday Inn

***SPRINGFIELD, MISSOURI**
Sunday, June 26, 1960
The Holiday Inn

***ROANOKE, VIRGINIA**
Saturday, July 16, 1960
The Hotel Roanoke

***SANTA ROSA, CALIFORNIA**
Friday, September 16, 1960
The Flamingo Hotel

***KANSAS CITY, KANSAS**
Friday, September 23, 1960
Battenfeld Memorial
Auditorium

HOUSTON, TEXAS
Saturday, September 24, 1960
The Shamrock Hilton Hotel

DEFIANCE, OHIO
Wed., September 28, 1960
Defiance College

PHILADELPHIA, PENN.
Sunday, October 16, 1960
The Sheraton Hotel

***HARTFORD, CONNECTICUT**
Thursday, October 20, 1960
The Statler Hotel

***GREAT FALLS, MONTANA**
Saturday, October 22, 1960
The Rainbow Hotel

ROCHESTER, NEW YORK
Wednesday, October 26, 1960
The Manger Hotel

CHARLESTON, WEST VIRGINIA
Sunday, October 30, 1960
The Daniel Boone Hotel

SIOUX FALLS, SOUTH DAKOTA
Tuesday, November 1, 1960
The Sheraton-Cataract Hotel

***CHARLOTTE, N. CAROLINA**
Thursday, November 3, 1960
The Hotel Charlotte

***CLEVELAND, OHIO**
Wednesday, November 9, 1960
Pick Carter Hotel

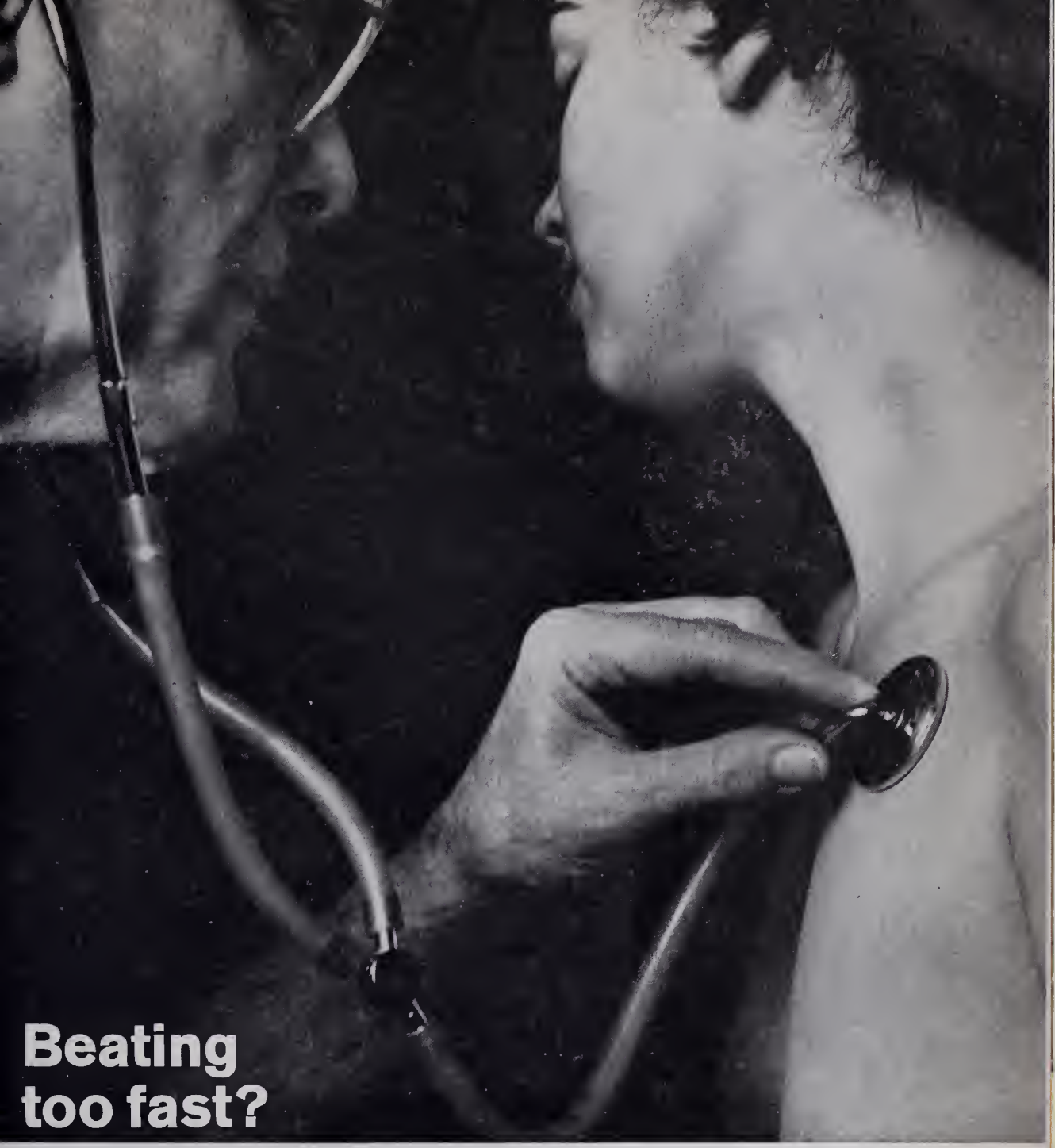
***SOUTH BEND, INDIANA**
Friday, November 18, 1960
The Pick-Oliver Hotel

WESTCHESTER COUNTY, N. Y.
Wednesday November 30, 1960
Westchester Country Club

ST. PETERSBURG, FLORIDA
Saturday, December 3, 1960
Tides Hotel and Bath Club

*Acceptable for Category I Credit for members of American Academy of General Practice

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.



Slow it down with SERPASIL®

(reserpine CIBA)

Serpasil has proved effective as a heart-slowing agent in the following conditions: mitral disease; myocardial infarction; cardiac arrhythmias; neurocirculatory asthenia; thyroid toxicosis; excitement and effort syndromes; cardiac neurosis; congestive failure. Serpasil should be used with caution in patients receiving digitalis and quinidine. It is not indicated in cases of aortic insufficiency.

SUPPLIED: Tablets, 0.1 mg., 0.25 mg. (scored) and 1 mg. (scored). Complete information available on request.

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WEBCOR REGENT CORONET STEREO HI-FI TAPE RECORDER **$329.95**

- Will record and play back both stereo and monaural tapes
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- Dual-channel 16-watt amplifier
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DEPT. STORES AND BETTER MUSIC, RECORD, CAMERA AND APPLIANCE DEALERS

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to relieve itching, burning skin lesions
just press the button on the can

Schering

METI-DERM® AEROSOL

prednisolone topical

for all steroid-responsive skin lesions · available with or without neomycin

S-472

there's
a better
move
than
scratching...



now–for more comprehensive control of

'pain & spasm'



INDICATIONS:

-pain due to or associated with -spasm of skeletal muscle

a new muscle relaxant-analgesic

Robaxisal®

ROBAXIN® WITH ASPIRIN

Many conditions, painful in themselves, often give rise to spasm of skeletal muscles. ROBAXISAL, the new dual-acting muscle relaxant-analgesic, treats both the pain and the spasm with marked success: In clinical studies on 311 patients, 12 investigators[1] reported satisfactory results in 86.5%. Each ROBAXISAL Tablet contains:

- A relaxant component — Robaxin* — widely recognized for its prompt, long-lasting relief of painful skeletal muscle spasm, with unusual freedom from undesired side effects. . . . . 400 mg.

*Methocarbamol Robins. U.S. Pat. No. 2770649

- An analgesic component—aspirin—whose pain-relieving effect is markedly enhanced by Robaxin, and which has added value as an anti-inflammatory and anti-rheumatic agent. . . . (5 gr.) 325 mg.

INDICATIONS. ROBAXISAL is indicated when analgesic as well as relaxant action is desired in the treatment of skeletal muscle spasm and severe concurrent pain. Typical conditions are disorders of the back, whiplash and other traumatic injuries, myositis, and pain and spasm associated with arthritis.

SUPPLY: ROBAXISAL Tablets (pink-and-white, laminated) in bottles of 100 and 500.

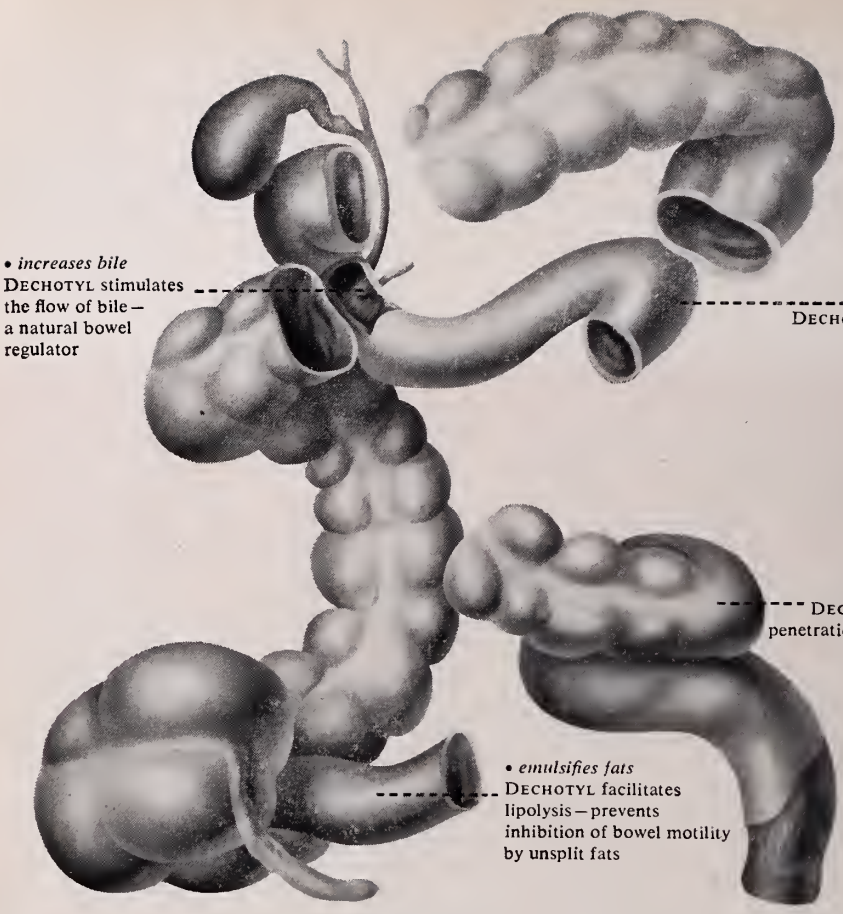
Also available: ROBAXIN Injectable, 1.0 Gm. in 10-cc. ampul. ROBAXIN Tablets, 0.5 Gm. (white, scored) in bottles of 50 and 500.

[1] Clinical reports in files of A. H. Robins Co., Inc., from: J. Allen, Madison, Wisc., B. Billow, New York, N. Y., B. Decker, Richmond, Va., C. Freeman, Jr., Augusta, Ga., R. B. Gordon, New York, N. Y., J. E. Holmblad, Schenectady, N. Y., L. Levy, New York, N. Y., N. LoBue, Chicago Heights, Ill., H. Nachman, Richmond, Va., A. Poindexter, Los Angeles, Cal., E. Rogers, Brooklyn, N. Y., K. H. Strong, Fairfield, Ia.

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Making today's medicines with integrity . . . seeking tomorrow's with persistence



helps free your patient from both... constipation and laxatives

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TRABLETS*

well tolerated...gentle transition to normal bowel function



Recommended to help convert the patient—naturally and gradually—to healthy bowel habits. Regimens of one week or more are suggested to assure maintenance of normal rhythm and to avoid the repetition of either laxative abuse or constipation.

Average adult dose: Two TRABLETS at bedtime as needed or as directed by a physician. *Action usually is gradual, and some patients may need 1 or 2* TRABLETS *3 or 4 times daily.*

Contraindications: Biliary tract obstruction; acute hepatitis.

DECHOTYL TRABLETS provide 200 mg. DECHOLIN,® (dehydrocholic acid, AMES), 50 mg. desoxycholic acid, and 50 mg. dioctyl sodium sulfosuccinate, in each trapezoid-shaped, yellow TRABLET. Bottles of 100.

*AMES T.M. for trapezoid-shaped tablet.

AMES
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When unaccustomed work produces

LOW BACK PAIN

Trancopal®

A TRUE "TRANQUILAXANT"

relaxes skeletal muscle spasm

Trancopal®

BRAND OF CHLORMEZANONE



relieves
the pain
and disability
of
musculoskeletal
disorders

When enthusiastic gardening – or any of a host of other pleasant summer activities – brings on low back pain associated with skeletal muscle spasm, your patient need not be disabled or even uncomfortable for any length of time. The spasm can be relaxed with Trancopal, and relief of pain and disability follows promptly. The patient can usually continue his normal activities while taking Trancopal.

Lichtman[1,2] used Trancopal to treat patients with low back pain, stiff neck, bursitis, rheumatoid arthritis, osteoarthritis, trauma and postoperative muscle spasm. He noted that Trancopal brought satisfactory relief to 817 of 879 patients (excellent in 268, good in 448, fair in 101). "Chlormethazanone [Trancopal] not only relieved painful muscle spasm, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."[1]

Gruenberg[3] also prescribed Trancopal for 70 patients with low back pain and observed that it brought marked improvement to all of them. "In addition to relieving spasm and pain, with subsequent improvement in movement and function, Trancopal reduced restlessness and irritability in a number of patients."[3] In another series of 193 patients Kearney[4] obtained relief with Trancopal in 181 patients suffering from low back pain and other forms of musculoskeletal spasm.

Trancopal enables the anxious patient to work or play. According to Gruenberg, "In addition to relieving muscle spasm in a variety of musculoskeletal and neurologic conditions, Trancopal also exerts a marked tranquilizing action in anxiety and tension states."[3] Lichtman[1] found that his patients in anxiety and tension states ". . . were in many instances able to continue their normal activities where previously they had been considerably restricted in their activities."[1] ". . . Trancopal is the most effective oral skeletal muscle relaxant and mild tranquilizer currently available." (Kearney)[4]

Side effects are rare and mild. "Trancopal is exceptionally safe for clinical use."[3] In the 70 patients with low back pain treated by Gruenberg,[3] the only side effect noted was a mild nausea which occurred in 2 patients. In Lichtman's group, "No patient discontinued chlormethazanone [Trancopal] because of intolerance."[1]

A TRUE "TRANQUILAXANT"

Trancopal

potent muscle relaxant

effective tranquilizer

- In musculoskeletal disorders, effective in 91 per cent of patients.[5]
- In anxiety and tension states, effective in 89 per cent of patients.[5]
- Low incidence of side effects (2.3 per cent of patients).
  Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage. It does not affect the hematopoietic system or liver and kidney function.
- No gastric irritation. Can be taken before meals.
- No clouding of consciousness, no euphoria or depression.

Indications:

Musculoskeletal disorders
Low back pain (lumbago)
Neck pain (torticollis)
Bursitis
Fibrositis
Myositis
Ankle sprain, tennis elbow
Osteoarthritis
Rheumatoid arthritis
Disc syndrome
Postoperative muscle spasm

Psychogenic disorders
Dysmenorrhea
Premenstrual tension
Anxiety and tension states
Asthma
Angina pectoris
Alcoholism

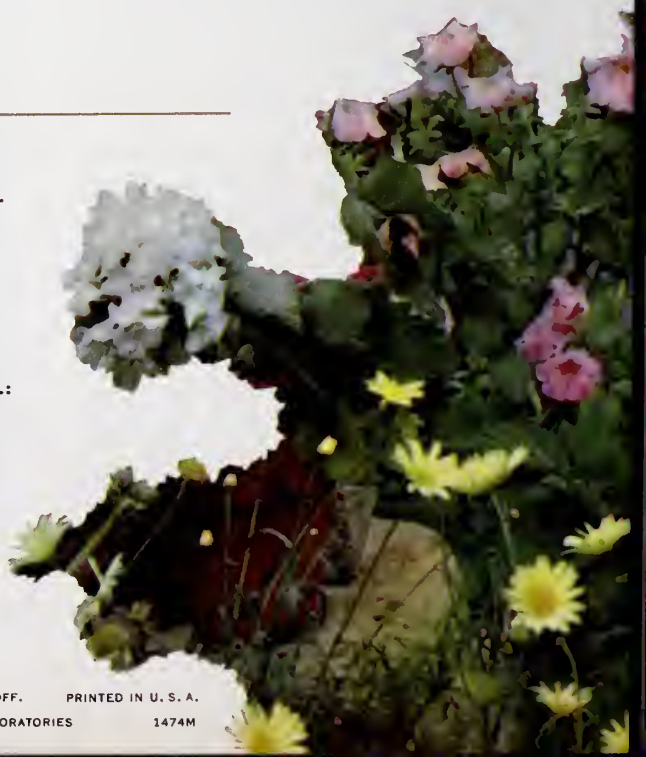
How Supplied: Trancopal Caplets®

200 mg. (green colored, scored), bottles of 100.

100 mg. (peach colored, scored), bottles of 100.

Dosage: Adults, 200 or 100 mg. orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

References: 1. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958 • 2. Lichtman, A. L.: Scientific Exhibit, Internat. Coll. Surgeons, Jan. 4-7, 1959, Miami Beach, Fla. • 3. Gruenberg, F.: *Current Therap. Res.* 2:1, Jan., 1960 • 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960 • 5. Collective Study, Department of Medical Research, Winthrop Laboratories.



Winthrop LABORATORIES
New York 18, N.Y.

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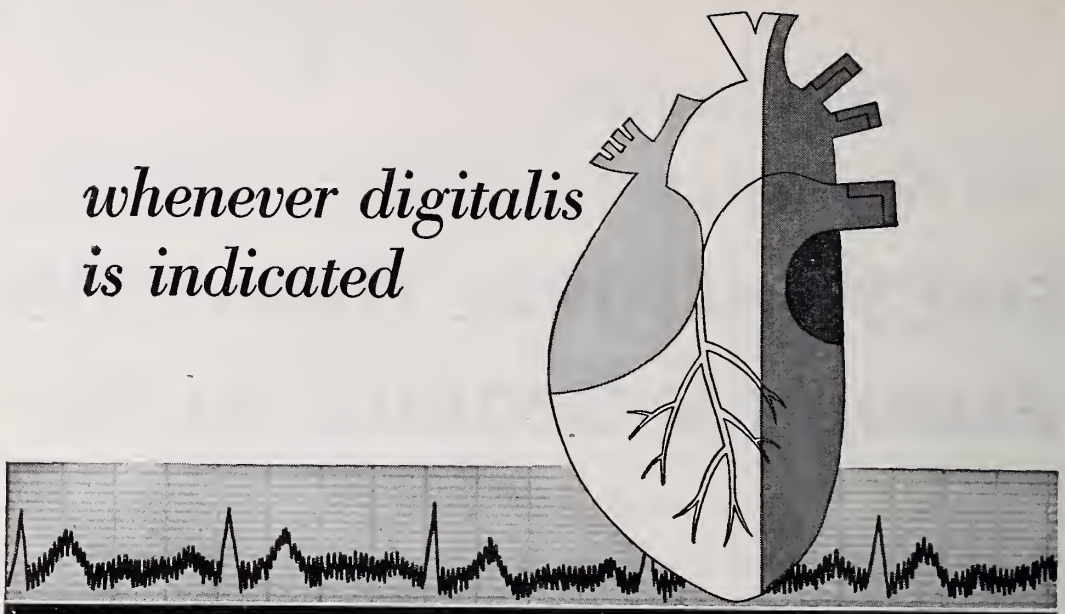
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"If one digitalis agent were to be recommended for its adaptability to the many and varied clinical contingencies, we believe Digoxin would be the drug of choice."

Lown, B., and Levine, S. A.: Current Concepts in Digitalis Therapy, Boston, Little, Brown & Company, 1954, p. 23, par. 2.

'LANOXIN' TABLETS	'LANOXIN' INJECTION	'LANOXIN' ELIXIR PEDIATRIC
0.25 mg. scored (white) 0.5 mg. scored (green)	0.5 mg. in 2 cc. (I.M. or I.V.)	0.05 mg. in 1 cc.

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now –

control

virtually all runaway diarrheas.. promptly, effectively with



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Robins

or Donnagel® with Neomycin

Prompt and more dependable control of virtually all diarrheas can be achieved with the comprehensive DONNAGEL formula, which provides adsorbent, demulcent, antispasmodic and sedative effects—with or without an antibiotic. Early re-establishment of normal bowel function is assured—for all ages, in all seasons.

DONNAGEL: In each 30 cc. (1 fl. oz.):

Kaolin (90 gr.)	6.0 Gm.
Pectin (2 gr.)	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

DONNAGEL WITH NEOMYCIN

Same formula, plus

Neomycin sulfate	300 mg.

(Equal to neomycin base, 210 mg.)

A. H. ROBINS CO., INC., Richmond 20, Virginia · *Ethical Pharmaceuticals of Merit since 1878*

PROVEN . . . MILLIONS USED . . . *effectively*

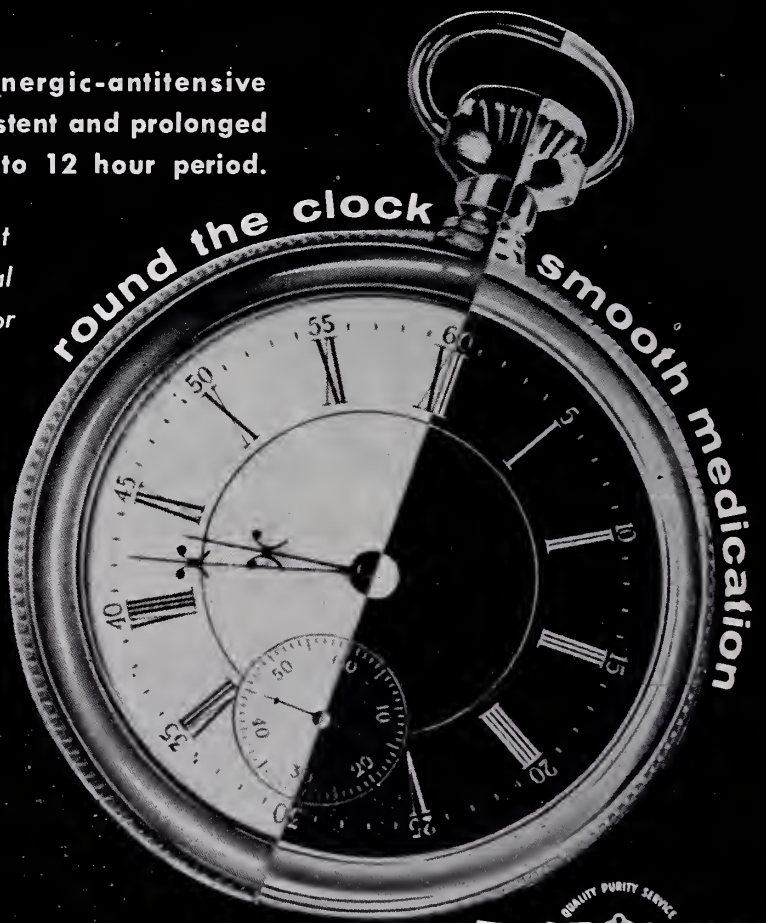
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RELAXES THE SPASTIC G. I. TRACT **RELIEVES NAUSEA IN PREGNANCY**

Provides superior anticholinergic-antitensive action through smooth, consistent and prolonged release of drugs over a 10 to 12 hour period.

The rate of release is independent of location in the gastrointestinal system—the same rate in ***ACID*** *or* ***ALKALINE*** *media.*



DOSAGE: One tablet morning and night.

Each Ty-Med* tablet contains:

Amobarbital	50 mg.
Homatropine Methylbromide	7.5 mg.

*LEMMON Brand of timed-release medication.

A clinical supply of SED-TENS Ty-Med tablets is available from . . .

LEMMON PHARMACAL CO.
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PHARMACAL COMPANY

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TRICOFURON IMPROVED (Suppositories and Powder) cured 143 of 161 patients with vaginitis due to Trichomonas vaginalis, Candida (Monilia) albicans, or both. "Almost immediate symptomatic improvement was noted with the first insufflation."

Criteria for cure: freedom from infecting organisms as well as symptoms on repeated examinations during a three-month follow-up. This cure rate of 88.8% is "surprisingly similar" to results reported by earlier investigators.

Coolidge, C. W.; Glisson, C. S., and Smith, A. S.: J.M.A. Georgia 48:167, 1959.

TRICOFURON®

IMPROVED

2-step treatment brings swift relief, eradicates stubborn trichomonads, Candida (Monilia) albicans, Hemophilus vaginalis

1. POWDER for weekly insufflation in your office. MICOFUR®, brand of nifuroxime, 0.5% and FUROXONE®, brand of furazolidone, 0.1% in an acidic water-dispersible base.

2. SUPPOSITORIES for continued home use —1st week one suppository in the morning and one on retiring. After 1st week, one suppository at night may suffice.

Continue use of suppositories during menses. Treatment should be continued throughout a complete menstrual cycle and for several days thereafter. MICOFUR 0.375% and FUROXONE 0.25% in a water-miscible base.

Rx new box of 24 suppositories with applicator for more practical and economical therapy.
Also available:
box of 12 suppositories with applicator.

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Triaminic®

...relief from pollen allergies

more complete than antihistamines alone... more thorough than nose drops or sprays

The miseries of respiratory allergy can be relieved so effectively with Triaminic.[1-5] Triaminic contains two antihistamines plus the decongestant, phenylpropanolamine, to help shrink the engorged capillaries, reduce congestion and bring relief from rhinorrhea and sinusitis.[1] Oral administration distributes medication to *all* respiratory membranes without risk of "nose drop addiction" or rebound congestion.[2,3]

Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

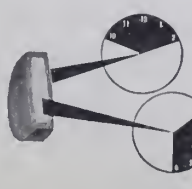
also available:

TRIAMINIC JUVELETS® ½ the formulation of the Triaminic Tablet with timed-release action.

TRIAMINIC SYRUP each teaspoonful (5 ml.) provides ¼ the formulation of the Triaminic Tablet.

References: 1. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. 2. Lhotka, F. M.: Illinois M. J. 112 259 (Dec.) 1957. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Fuchs, M.; Bodi, T., Mallen, S. R.; Hernando, L., and Moyer, J. H.: Antibiotic Med. & Clin. Ther. 7:37 (Jan.) 1960. 5. Halpern, S. R., and Rabinowitz, H.: Ann. Allergy 18:36 (Jan.) 1960.

Relief is prompt and prolonged because of this special timed-release action



first—the outer layer dissolves within minutes to produce 3 to 4 hours of relief

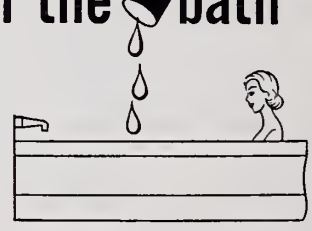
then—the core disintegrates to give 3 to 4 more hours of relief



for **dryness** and **itching,** prickly heat and rash
intertrigo, insect bites, other summer skin discomforts

Sardo®

in the bath





1. Spoor, H. J.: N. Y. State J. Med., Oct. 15, 1958

SARDO acts promptly to help restore needed natural oil and moisture[1] to dry, itchy skin, by helping to re-establish the normal lipid-aqueous balance. Thus SARDO eases irritation, soothes, softens, brings sustained comfort.

USED IN THE BATH, SARDO releases millions of microfine water-dispersible globules* to provide an emollient suspension which enhances your other therapy . . . in prickly heat, intertrigo, insect bites, skin dryness and itch of atopic dermatitis, eczematoid dermatitis, senile pruritus, soap dermatitis, etc.[1]

Patients appreciate pleasant, convenient, easy-to-use SARDO. Non-sensitizing. Most economical. Bottles of 4, 8 and 16 oz.

Write for *Samples* and literature . . .

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In disabling rheumatoid arthritis. A 62-year-old printer incapacitated for three years was started on DECADRON, 0.75 mg./day. Has lost no work-time since onset of therapy with DECADRON one year ago. Blood and urine analyses are normal, sedimentation rate dropped from 36 to 7. He is in clinical remission.*

New convenient b.i.d. alternate dosage schedule: the degree and extent of relief provided by DECADRON allows for b.i.d. maintenance dosage in many patients with so-called "chronic" conditions. Acute manifestations should first be brought under control with a t.i.d. or q.i.d. schedule.

Supplied: As 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100. Also available as Injection DECADRON Phosphate. Additional information on DECADRON is available to physicians on request. DECADRON is a trademark of Merck & Co., Inc.

From a clinical investigator's report to Merck Sharp & Dohme.

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Lifts depression..



You see an improvement within a few days
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Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function–frequently reported with other antidepressant drugs.

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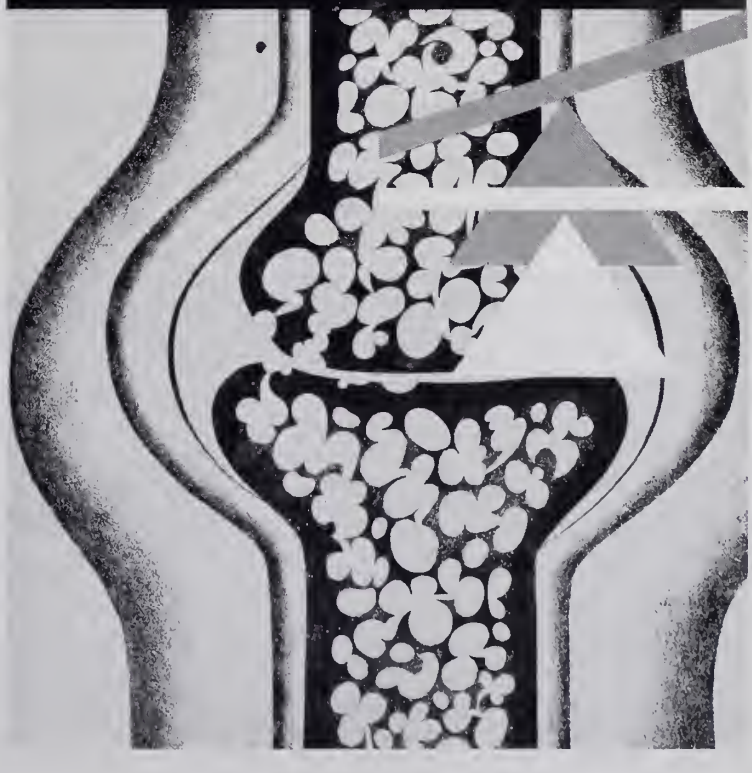


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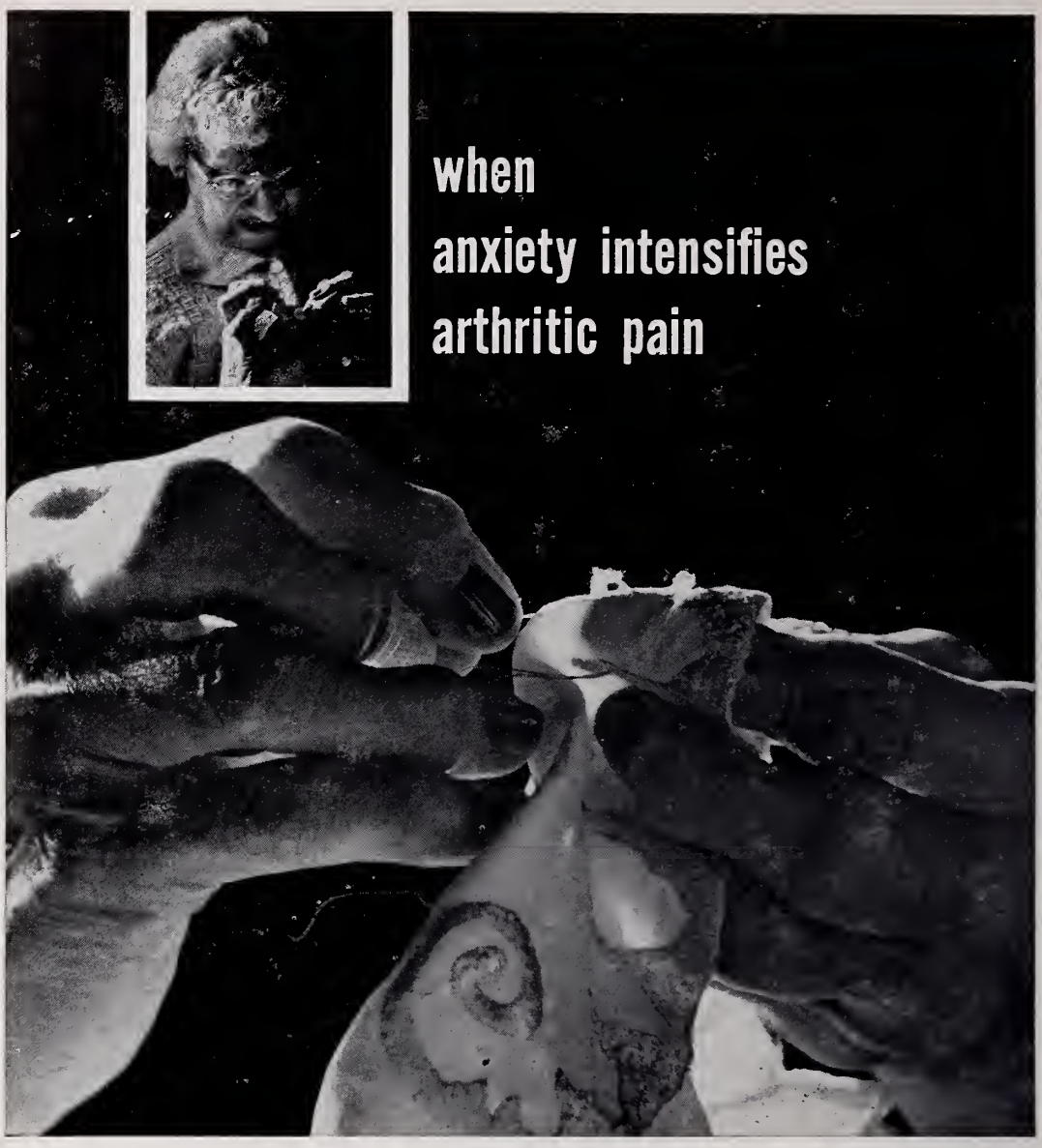
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THE JOURNAL
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Editorials • • •

Our New President



Installed last month, to preside over our destinies during this fateful year, was Jesse McCall, M.D. Born in Virginia in 1906, he received his baccalaureate degree at Virginia Military Institute in 1927, and his M.D. at the Medical College of Virginia in 1931. In medical school, he won an Alpha Omega Alpha membership. He interned at Boston City Hospital, and then did graduate study there as a resident in internal medicine. Dr. McCall had a year of psychiatry at the well-known Tucker Sanitarium in Richmond. In 1934 he settled in Newton, N. J. and immediately became active in the affairs of the Sussex County Medical Society, rising through all offices there and eventually becoming president of that body. He also had a tour of duty as president of the Sussex Chapter of the N. J. Heart Association. Dr. McCall was a lieutenant colonel in the Army of the United States during World War II and won a com-

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bat star in the Guadalcanal campaign. He is married to the former Louise Richardson Pregnall of Richmond, Va.

Dr. McCall is a diplomate of the American Board of Internal Medicine, and an F.A.C.P. He has been president of the local Rotary Club and for some time served as treasurer of The Medical Society of New Jersey. He is now chief of the medical service at the Newton Memorial Hospital.

The One Shot "Cure" for Allergy

Patients are beginning to ask their doctors about a 'single injection" treatment for allergy —described in the less elegant periodicals as "the one shot cure." The correct designation is: repository method of hyposensitization. The facts, as furnished to our editorial office by the New Jersey Allergy Society, appear to be as follows.

The repository method consists of mixing an aqueous extract of the allergen with mineral oil and emulsifying it with an appropriate agent. This must be done with meticulous care and precision to insure a perfect emulsion. Anything short of complete emulsification makes the preparation unsuitable and invites severe constitutional reactions which could be fatal. Although this method of preparing an extract is not entirely new (it was done by Natterman in Boston in 1938) it has come to the fore in the past 10 years through the independent work of Dr. Loveless in New York and Dr. Brown in Boston. Under the stimulus of numerous articles published by them, many allergists throughout the country have been trying this procedure independently to determine its value and safety.

Recently the American Academy of Allergy instituted a nationwide study under controlled conditions to test the efficacy of this method. They have assigned leading members of their organization to study this form of therapy independently and to report their findings in 1961. At that time all results will be collected and tabulated. The information will then be evaluated on the basis of these important criteria:

1. Stability of the emulsion
2. Safety of the preparation
3. Clinical effectiveness

Should it satisfy these criteria, it would be submitted to the Food and Drug Administration. If approval is granted, it would then become commercially available. Until such time as approval is obtained the emulsified extract will not be available for general medical use.

Most of the allergists are still treating their patients in the conventional manner with a series of regular injections given either preseasonally or all through the year.

The Doctor As a Scapegoat

A recent committee report appears to indict physicians as the major factor in the rising costs of hospital care. Actually, if the report is read in full, there is evidence that the members of the committee realize that better drugs and better equipment are responsible for increased costs; and that these increases are counterbalanced by shorter hospital stay, shorter disability, and lives saved. Anyone thinking about it carefully must see that it was cheaper to treat septicemia half a century ago when the doctor administered salicylates and ordered the nurse to sponge the patient frequently. However, most of these pa-

tients died. Modern chemotherapy costs more per dose than old-fashioned salicylates, but most patients today survive septicemia. Under the circumstances it is fatuous to call on the physicians to lower costs by prescribing cheaper drugs or using antiquated equipment.

While this is obvious to any sophisticated person who reads the whole report, most people will see only the headlines and opening paragraphs. According to the headlines doctors are held accountable for mounting hospital costs. The opening paragraph said that "physicians will have to take responsibility for cutting hospital costs."

This is only the latest of the pin pricks to put the physician in an unfavorable light. For the past several decades now the private practitioner has been pictured as fee-conscious, and unwilling to respond to emergencies. It is interesting to wonder what accounts for this blemished image of the medical practitioner. Why is it that the doctor of a century ago who could do so little to prolong life and cure disease was revered, when his more efficient counterpart today is being so severely criticized?

It has been suggested that part of the difficulty is that, in their effort to democratize medical practice, physicians are taking patients more and more into their confidence, thus reducing the mystery of medicine and the awe with which physicians used to be held. The practice of medicine does not really lend itself to the buddy system. The patient must have complete confidence in the doctor and familiarity often does breed contempt. Whatever the cause, the current image of the doctor is frequently an unhappy one. All of us in organized medicine must take the lead to destroy this image and replace it with one of idealism. Perhaps our model should not be the conspicuously prosperous practitioner but rather the modest one like Albert Schweitzer or Thomas Dooley. One may wonder in whose interest it is to make the doctor a perpetual scapegoat. If the fault was not ours originally, the remedy now lies in our hands.

Unlabeled Poisons

Kitchen shelves and home medicine chests abound in drugs, chemicals, cosmetics and cleaning agents. Many of these are poisonous, but there is, for most of them, no legal requirement that they be so labeled. Last year 1500 Americans (a fourth of them young children) died from home contact with packaged chemicals. Gravely concerned about this, the American Medical Association urges the enactment of HR 7352 (Curtis) which would regulate the labeling of hazardous substances distributed to homes. Manufacturers don't like this kind of legislation—and some people are, in general, opposed to further restrictions of individual liberty. The AMA, surely no advocate of "government interference," feels that a law like this is a public health necessity—and it is hard to disagree.

Some manufacturers fear that labels will frighten off potential customers—but medical organizations can hardly be asked to be concerned about that when the alternative is a serious health hazard. To be sure, preschool children won't be able to read the labels. But their parents can—and will put such dangerous packages out of the reach of childish hands.

Incidentally, this aspect of our A.M.A. program doesn't seem to get nearly the publicity that attends A.M.A. opposition to proposals like the Forand Bill. Many observers see organized medicine as a kind of guild to protect the interests of physicians. Yet much of A.M.A.'s energy, funds and time are expended in quiet campaigns like this that can contribute nothing to the personal fortunes of any doctor—nothing except the satisfaction of striking a blow for human health.

RICHARD E. GORDON, M.D.

Englewood

Psychotherapy by the Family Physician*

To the sophisticated family doctor, psychotherapy offers a challenging field of usefulness. Of course the good doctor has always been a psychotherapist. Dr. Gordon here reviews some of the problems of psychotherapy by the general practitioner.

THIS paper will suggest to the family physician means by which he can better understand and manage the emotional problems of many of his patients. The family doctor regularly advises, counsels, and influences his patients, not only with their physical difficulties, but also regarding social and emotional matters. This paper will concentrate on the practical realities of patients' lives. It will not be concerned with more probing "psychoanalytic" matters, which are more adequately presented elsewhere.

The physician can offer much assistance in helping patients adjust if he has some understanding of these three different categories: (1) the individual problem of each patient related to his personal life history, (2) the specific problems of his role in life, such as his age, sex and marital position, his cultural milieu, and the social expectations of him, and (3) learning principles generally applicable for flexible, intelligent adjustment to life in a rapidly changing world.

Every individual can be seen in relation to his heredity, early environment, education and present life-position. Generally, pathologic, emotional and psychosomatic reactions were established in the constitutionally susceptible patient's history by unfortunate experiences. These events often (but not always) occurred fairly early in life. Repetition trained the reactions to become habitual and automatic, conditioned to danger signals in every day life. Many of the earlier painful reactions and thoughts arose in relation to people or commonplace situations. Abnormal responses in later life, for which the patient will consult the physician, are also generally stimulated by comparable relationships with people and similar situations.

Many painful experiences may have been necessary to establish a pattern of psychopathologic behavior; but once it has been established much milder punishments can keep it going. Many people's lives are filled with milder stresses which keep their already overloaded emergency neurologic, endocrine and psychologic processes continually "straining." Completely harmless signals, once associated with danger and punishment, can automatically elicit the full psychopathologic response, if not extinguished.

THE SPECIFIC ROLE PROBLEM

EVERY individual has different demands and expectations of him which are related to his age, sex, marital status, economic position, ethnic origin, education, social status and so on. In our ever-changing world people often

*Dr. Paul Eiserer, Dr. John E. McWhorter, Eli E. Kapostins, and Katherine K. Gordon helpfully reviewed and criticized this paper.

are poorly prepared for situations in which they may find themselves. Such persons may have had little past experience, preparation and training for new responsibilities and cannot cope. The older generations often trained their offspring in attitudes, values, and codes of behavior, which were traditional and satisfactory in their day but which may be less acceptable and useful in the present. Pathologic reflexes established by unfortunate experiences earlier in life may become restimulated by the new, stressful events of later life, associated with new duties, living in new environments, and adjusting to people of different backgrounds.

INTELLIGENT ADJUSTMENT TO A CHANGING WORLD

INDIVIDUALS may be required to learn to increase their abilities in order to cope with complicated situations in a changing environment. Some of the factors in this process are: (1) Individuals generally must be motivated to understand and control the influences of the environment upon their emotions. It is often difficult to educate unmotivated people to change their responses. (2) The person who is willing to *think* about and works to improve his situation will benefit from rewards for his efforts from important persons in his environment (family, friends, employer, etc.) He will tend to falter less when subject to control and discipline by persons with authority. A moderate amount of punishment for errors by those in control can alert him and contribute to better use of his intelligence. (3) Society rewards performance. Only the specially privileged (financially, socially, politically, and so forth) can relieve themselves of emotional difficulties without facing responsibilities and contributing. Less fortunate fellow sufferers usually must cope with the environment for security and for survival. They often have been firmly required to strive and perform, then rewarded, and thus have learned to persevere for their goals and happiness. Such learning did not develop spontaneously; example was usually necessary. (4) New learning is best accomplished by rewarding step-by-step progress. Smaller efforts are praised and rewarded, then larger, and still larger, with decreasing rewards necessary at each stage. Big demands, perfectionistic expectations and requirements are fine as ideals, but can be demoralizing in the early stages of learning. (5) Patience, emotional control, self-discipline, persistence, and perseverance are also learned and achieved one step at a time, with appropriate rewards for small but continuing efforts. (6) Guidance by trusted, dependable, experienced helpers and companies can assist learning. Brainstorming sessions for cross-fertilization of ideas benefit people in all walks of life. (7) Since individuals must generally rely and depend upon others, they do well to learn consideration and courtesy toward others. (8) Persons who wish to learn from others how better to succeed have the responsibility to see that they are understood, to communicate their questions and ideas intelligently. (9) Individuals can learn to assert themselves discreetly, tactfully, but firmly to achieve their own goals, to prevent others from exploiting and hurting them, and yet not provoke further punishment. More is accomplished by building better than one's opponents and thus winning the respect of both the opposition and the neutral observers. Destructive efforts may injure both the defenders and aggressors. (10) People can respect their limitations and develop systems of relative values that are appropriate to their situations. Young mobile families generally might place economic security, health, love, consideration, and service highest, orderliness, education and training on the second level, and material possessions, social status, and perfectionistic concerns about appearances lowest on their scales. In due course, with continuing effort, but with time out for relaxation and just plain living, all can be accomplished. No one need sacrifice, just go more carefully and enjoy the process.

MANAGEMENT

IN PSYCHOTHERAPY, events from the individual's past life, both distant and immediate, are reviewed and studied. Hindsight leads to

insight as to means of reducing the painful effects of unpleasant experiences. Discussion and foresight help the patient profit from his experiences and learn how better to prepare for, avoid, control, or adjust to similar difficulties in the present and future. Patients gain insight into *what* upsets them, *why,* it is happening (the early conditioning as well as the actual physiologic process), and *how* to prevent future similar trouble and to enjoy life constructively.

Improvements in psychotherapy take place as a result of "extinction." Autonomic and endocrine responses function automatically, but human beings have the additional ability to comprehend and understand the mechanisms of conditioning and extinction. They can be shown the important influences in their lives and the effects upon their emotions. They themselves often can reorganize their lives. They *consciously* can take actions to retrain their automatic processes accordingly, and eradicate abnormal emotional reactions when necessary.

However this is not always easy. There is a tendency in every patient to resist extinction from fear. Some people have little education, less self-control, and their environmental situations are not much under their control. New learning is often necessary to prepare the situation for extinction to proceed.

Patients and their families can study what factors provoke the abnormal emotional reactions and learn how to remove any realistic sources to permit extinction of pathologic emotional reactions. More fortunate people can carefully remove the dangers associated with certain difficult situations and then force themselves slowly into the situation. They can use their higher intelligences to see to it that they receive rewards for their efforts, and have less afraid companions upon whom to lean when they are fearful. Sometimes employers and "superiors" have control over the environment. Physicians usually do not have much "power" for they personally can rarely influence the important features in patients' lives.

The counseling physician helps the patient think, discuss and plan more before acting, and react less autonomically. Once the patient can think about the problems and their effects upon him more intelligently, he is better able to develop methods of control and adjustment. He then can diminish one-by-one those unpleasant experiences in his present life which continually recondition his anxiety and other pathologic emotional reactions. New shocks must meanwhile be prevented.

WHEN the present situation is fundamentally favorable and pleasurable, and does not contribute to strengthening of abnormal responses, simple "extinction" can take place. Verbalization is helpful, but rarely are words alone curative. It is usually necessary for the patient to re-expose himself to those of the no longer dangerous but still feared situations which are important to his happy living. This process proceeds more effectively and less painfully when: (1) facing the fearful situation is first in small, then in gradually larger doses; (2) each step is encouraged, praised, and rewarded, with larger rewards at first, smaller later; and (3) a helpful, trusted, unafraid escort or companion is available.

Very fearful and withdrawn persons are often too anxious to do this alone. It is futile to demand that the patient "get a hold of himself," to tell him "it's all in his head" and that he is "not trying to help himself," that he should "snap out of it." Mental hospital care, and shock treatments, although helpful in certain cases, are not curative alone. Financially—they can be costly; socially—the patient may be stigmatized; and psychologically—the electroconvulsive therapy and hospitalization are sometimes frightening. Only a patient who represents a peril to his own or another's life, limb and property generally must be institutionalized.

Psychopharmacologic agents, shock treatments, and hospital care are adjuncts to the curative effects of successful living. They assist the patient and support his and his family's efforts until he has begun to achieve. With encouragement from those whom he respects (noting the improvements he and family have made in his life) observing that he can remove the sources of his fears and extinguish his anxieties, he comes realistically to appraise himself more favorably. As soon as

he can have confidence in the structure he himself has built, the temporary supports can be removed.

The patient discusses new ways to satisfy his interests and desires, and plans intelligent steps to remove and avoid the pitfalls and dangers. Conference with others who have had success in coping with similar situations, comparing notes and methods, can help an individual plan and prepare better. The physician-counselor, having much personal experience of his own and with his patients can offer many alternative courses of action to the patient. This weighing of what succeeded painlessly and what resulted in the unpleasantness in one's own and others' lives leads to more careful plans for the future. Various possible courses of action, some more successful, others less, are considered. As cautious testing follows planning, and results in occasional success, new more appropriate habits are established.

Once a patient has under way a program for improving his situation, he begins to feel more hopeful. Now when fearful thoughts arise he may be able to distract himself by thinking of other things such as the better life to come or his newly-evident accomplishments. He may steel himself to make a fresh start. Self-control becomes more possible when an individual has hopeful experiences and activities to which to turn his attention. The patient whose situation remains pain-inducing often cannot be distracted. He remains fearful, his attention fixed upon himself and his problem, unable to concentrate on anything else.

A breadwinner generally responds better when he remains on the job. If he already has left, he should return as soon as possible. The individual, who takes his responsibilities seriously, can become severely, and suicidally depressed when he sees his emotional difficulties resulting in loss of a job. But as with all other psychotherapeutic progress, his effort at working should be stepwise. His employer should give credit to the considerable courage required in the patient's just returning to work. Employer and employee should limit temporarily expectations as to quantity and quality of performance. The patient will be able to perform larger responsibilities and a full day's work only gradually, as his doubts and fears subside. There should be little threat or force—with their real implication of the danger of losing his job. The patient need not give up ambitions for promotion and advancement, with consequent demoralization. Emotional difficulties can stimulate learning and greater understanding. The recovered patient can come to recognize and develop tolerance for others' realistic limitations, the point beyond which people cannot let themselves be pushed. This can lead to improved abilities in handling subordinates.

The housewife-mother does better when kept in the home. Loving, dependable female relatives and friends, public health nurses and homemakers help keep the family together and give her moral and practical support during her rehabilitation. Students who can be kept at or returned to their studies, often with a temporary reduction in their programs, and sometimes special tutoring, also respond quicker and better.

IMPROVING PSYCHOLOGIC RESPONSES

THE patient not only learns how to improve his life, but also develops better methods of expressing his needs and interests. He can learn with guidance more appropriate and adaptive responses. Anger, when mastered, can spur careful actions to bar future injuries. Suspicions and distrust, often well-founded in a competitive society, may promote caution in subsequent important transactions. The need for glory can be satisfied by continued intelligent efforts at socially commendable activities. Jealousy can mobilize efforts to serve the spouse directly, and indirectly by impressing her with repeated achievements, and thus to convince her of one's irreplaceability. Pride can serve to goad one to admirable and praiseworthy accomplishments. Resentment against exploitation may promote discrimination between one's realistic and unnecessary duties, stimulate awareness of one's limitations, and

mobilize a courteous firmness in dealing with future unreasonable demands. A tendency to criticize is usually welcomed when offered with considerate and helpful suggestions.

The patient may patiently postpone action in one sphere of interest, when it conflicts with other motives. Meanwhile he gives constructive attention to activities in which he can be more readily successful. He can learn to avoid impulsive and impetuous action. The therapist can guide the selfish patient to constructive means of satisfying his personal needs in a manner that benefits others—to enlightened self-interest.

People whose life situations are in a process of changing cannot readily establish easy routines in managing their affairs. They often find themselves exposed to new realistically difficult situations. The resulting trial and error necessary to their adjustment can result in painful mistakes. As a result, patients may receive much criticism and punishment from superiors, associates and conscience. They need to develop extraordinary skill in the use of intelligence for planning, preparing and reorganizing regularly.

The physician can be particularly helpful to *mobile patients* who consult him upon entering periods of change in their lives. People assume new roles and responsibilities upon entering college, military service, or marriage, moving residence, changing jobs, having a baby, at involution, retirement, or in old age. They often respond well to practical information regarding methods of succeeding as well as potential pitfalls.

Patients are often told to forget about their hurts and worries. In a changing competitive world unpleasantness may be repeated if ignored. It is usually not sensible to seek vengeance, and provoke retaliation. But it is wise to study past griefs, learn to take steps to prevent or avoid possible recurrences. Now that his worries and angers have served to stimulate steps to protect himself better, the patient can more readily put aside his fear.

The physician may continue regularly to schedule counseling sessions with his no longer distressed psychotherapy patients every four to six months and review their situations, just as he would periodically examine prophylactically his other patients. They might confer with him when new decisions are necessary in their ever-changing lives just as they would with their attorney or accountant.

DISAPPOINTMENTS

PATIENTS who come to the physician expecting him to remove their psychologic symptoms as the surgeon would excise a tumor will often be disappointed. Individuals whose life situations are desperate can accomplish little building quickly. They become discouraged when their need is so great and it takes so long to improve their situations and extinguish their fears. Families, friends and employers who constantly disparage, are impatient, demand perfection, who are unable to praise the small daily accomplishments of the patient-builder, often tear down the growing edifice as fast as the patient constructs it. They recondition his fears as fast, or faster, than he can extinguish them. Individuals in these situations usually develop more severe and less tractable emotional disorders.

Patients, particularly those without understanding, helpful families, may seek friendship from daily encouragement and advice of the therapist. They may become angry when they cannot talk to the doctor at will on the telephone, call on him and his family at his home, enjoy greater intimacy with him, or have him visit them socially. They want and need not only guidance but the affectionate cement of friendship. They may feel hurt to have to pay for insight and careful, intelligent, informed counsel, when they need more immediate and direct satisfactions.

A physician can get to know many of the important features of his patients' lives in a brief period of time. In counseling them regarding present day realities he need not devote long and frequent hours, and may often assume a more suggestive approach. The physician can guide his patients along sensible paths and let successes and accomplishments work their slow therapeutic effects.

EMERGENCIES

THE physician cannot help every patient he counsels find the solutions to his problems except with time and patience. In most cases, when emotional crises arise, he cannot accomplish much psychotherapeutically at the moment. He usually can do little more than provide sedatives.

The physician serves his patients best by avoiding participation in impetuous decisions. He generally should try to counsel postponement of action until intelligent conference can be held by all parties concerned in the quiet and professional atmosphere of his consulting room. People generally should not make important decisions when under the influence of strong emotion.

SELECTION OF PATIENTS

PHYSICIANS administer friendly psychotherapy to most of their patients in the routine course of caring for their physical needs. An inestimable amount of benefit is achieved from the kindly encouraging word, the reassurance, the thoughtful, understandable answer to a question. However, a physician may want to think twice about whether he should involve himself with a particular patient in more systematic and intensive psychotherapy.

Studies have shown a direct correlation between economic status, education, social status, intelligence, and responsiveness to the psychotherapeutic method described here. Individuals who have learned to study life objectively, including their own situations and emotional reactions, seek help sooner, accept and make use of counsel, and respond the best. People in good social situations are in a better position to modify their environments, remove emotionally disturbing annoyances, and respond favorably, whether in rehabilitation from an emotional difficulty or from a physical illness, such as a coronary thrombosis.

Housewives respond well when husbands are understanding and cooperative; they do badly when husband's situation (such as a traveling job), or attitudes interfere. Employees do well when their employers are helpful and patient, and assure them that they will hold their jobs as the patient readjusts. A harsh employer can ruin a physician's best psychotherapeutic efforts. Helpful family, friends, and employers can assist and support even the most disturbed patients undergoing agitated emotional collapses. They can help completely dependent patients back to normalness. When patients' social status and economic situations are going down hill, psychotherapy, and medical rehabilitation from physical disorders too, become tasks requiring great skill. To spend his efforts in less frustrating areas, the physician would best refer these patients to better trained specialists. A trial of three or four visits in one or two months will help a physician and patient determine whether the problem is within the therapist's skill and experience to manage.

Less encouraging is the outlook for divorced, widowed, and single men and particularly women, especially those past thirty years of age, aged persons, the unemployed, and the economically declining. Individuals whose skills are of increasing value to the economy do better than those whose background and training were for now-declining industries. Attractive, single young women respond better than homely ones. Thus in many instances the opportunities and difficulties in an individual's present social situation, and the people upon whom he can depend are as important for his prognosis as the numbers of unfortunate experiences in his past history and his symptomatic diagnosis.

CONFERENCES WITH FAMILY

IT IS important for the counseling physician to keep the trust of his patients. Many patients with emotional difficulties, particularly those who have previously been under psychiatric care, are suspicious of conferences in their absence. But cooperation of family and others in a position to help the patient can facilitate recovery. Relatives can learn how to help their loved one, understand him, and provide him with affection and guidance. This is

particularly true with the husband and parents of a housewife-patient. But discussion with family proceeds best in the presence, or with the full knowledge of the patient, and with him welcome if he wishes to come, not secretly nor over the telephone.

PSYCHIATRIC REPORTS

A PSYCHIATRIC label once given a patient, may remain for years, long after he has adjusted his life and his reactions, after it no longer is applicable. Diagnostic labels can hurt patients and interfere with their responses. The physician doing counseling tries to remove labels from patients, not attach them. It is sometimes necessary to submit a written report. It should be done honestly, but with minimal damage to the patient. The doctor should prepare medical and psychologic reports to lawyers, schools, courts or employers, in the presence of the patient whenever feasible. The patient then knows what is being said, signs a written authorization, contributes to the report's phrasing and knows how his physician was trying to cooperate. These reports should be requested in a letter for the physician's files. They may result in action which the patient feels is harmful to him. They should usually be marked *confidential,* and mailed directly to the requesting agency, not given to the patient or family. Then if the patient's wishes are not fulfilled, he does not so readily blame the doctor. And he may then be willing to continue his program of medical care and guidance with his physician, and improve his social and psychologic adjustment in society without distrust or loss of confidence in his medical guide.

THE TELEPHONE

THE telephone can be an instrument of the devil if used carelessly. You do poor psychotherapy over the telephone. The complicated, many-faceted problems that can arise in a patient's life usually require at least a half-hour of *vis-a-vis* conference, often with interested parties—family and others involved—to discuss and help. In telephone conversations the physician is unable to observe the expressions and emotions of his patient. The conversation may be hurried for the physician often is in the middle of doing something else. The telephone serves to make an office appointment within a reasonable time. The family and patient, appreciating that they will receive intelligent assistance privately, without the office nurse, the relative on the upstairs' extension, or the doctor's answering service listening in, generally calm down. Meanwhile the telephone does not jangle the ears of the patient in office consultation with the physician; it rings at the secretary's desk. The 'phoners' dilemmas do not consume half the time allotted to those in conference, nor cause embarrassment or resentment, nor interrupt the train of thought of the patient being treated in the physician's office.

NON-MEDICAL COUNSELORS

MANY other professional people—clergymen, social workers, clinical, school, and industrial psychologists, teachers, public health nurses, and others—are assuming counseling functions in response to an enormous social need. They can render some non-medical service—child and parent counseling, marital counseling, job counseling, and the like. Many of these "lay" counselors are well-trained, experienced, intelligent, stable people who do help patients. But there are problems that the family physician must recognize.

Non-medical counselors are not trained to recognize the very frequent medical complications in the patient's care, are less experienced with the side effects and complications of tranquilizers, sedatives and psychic energizers. They cannot obtain hospitalization for the patient who represents a peril to himself or society, nor arrange electroconvulsive therapy for the suicidally depressed. Many do not have regular conferences with psychiatrists to discuss possible complications or problems in management.

The physician can administer a careful examination for possible physical bases for the patient's complaints, provide early treatment, or inform the patient that he is physically sound. This can be very reassuring. The nonmedical therapist, who usually has not studied physiology, anatomy and pathology, can offer less of this aspect of psychotherapy; nor can he generally explain adequately the reasons for pain unassociated with actual pathology. In referring a patient to a lay therapist, the physician has not given up his responsibility for the medical care of the patient. He had better know what is going on and should continue to see the patient often, as physical complications are more common with those with emotional difficulties than with the more psychologically stable patient.

This is less of a problem when the patient is seeing a psychiatrist or a lay therapist who has regular psychiatric conferences for himself and his patients. The psychiatrist can and will more readily recognize non-psychologic physical signs and symptoms and should recommend and arrange appropriate examination and care, from the referring physician whenever possible.

COMMENT

THERE is reason to look to the future management of patients' emotional problems with increasing confidence. The population is becoming better educated and prepared for the new ways of life and their responsibilities and stresses. People continue to strive, develop their intelligences, and get ahead. Intelligent individuals are willing to become informed and help themselves. The educated are more educable.

Medical and social sciences will continue to collaborate and provide better information as to how psychologic problems can be managed. Family physicians, increasingly better informed in psychology and the social sciences, will be able to help their patients to this knowledge and thus guide them to happier, less tension-filled lives. Already an improved selection of intelligent, educated, and favorably situated patients expect and benefit from a more informed and scientifically sound psychotherapeutic guidance. Meanwhile social research will lead to improved community resources and attitudes. This will enable the presently less favorably situated to become more responsive to medical help and guidance.

275 Grand Avenue

Medical Economics Forum

The Sheraton Hotel in Philadelphia will be the scene of the next Medical Economics Forum on June 22. The program will run from 9:30 in the morning until 4:30 in the afternoon, and will be devoted to practical problems in office management. For more details write to Executive Director, Medical Economics Forum, 550 Kinderkamack Road, Oradell, New Jersey.

American Board of Obstetrics and Gynecology

The American Board of Obstetrics and Gynecology is receiving applications for the examination this fall. The deadline for the receipt of applications is August 1, 1960. No applications will be accepted after that date.

Attention is called to a change in requirements. Candidates coming to the Part II examination must bring with them a duplicate list of hospital admissions. For further information write to Dr. Robert L. Faulkner, 2015 Adelbert Road, Cleveland 6, Ohio.

Daniel B. Eck, M.D.

East Orange

Flexion-Extension Injury of the Cervical Spine*

In this automobile age, whiplash injury of the cervical spine is becoming more common. It is a tricky lesion, because the patient may feel all right immediately after the accident and thus be lulled into false security. How to detect the lesion and what to do about it are detailed in Dr. Eck's paper.

When flexion-extension (whiplash) injuries of the head and neck will occur during the presentation and discussion of this paper.[1] It is becoming more common with the increasing frequency of automobile collisions. Generally, the injury occurs as the result of a moving vehicle striking a stationary, or more slowly moving, vehicle from the rear. However, it may develop following a front end collision especially when there is some forward restraint such as a safety belt. Occasionally, a glancing or broadside blow may produce the same ultimate result.[2]

MECHANISM

A scholarly study[3] has been undertaken jointly by the Institute of Transportation and Traffic Engineering of the University of California and the School of Medicine of Yale University. Briefly, it points out that the pattern of injury is influenced by the:

1. Speed of contact.
2. Mass and collapse characteristics of the vehicles.
3. Height, strength and inclination of the seatback.
4. Variations in height, weight, age and posture of the involved individual.
5. Defensive reflex time.

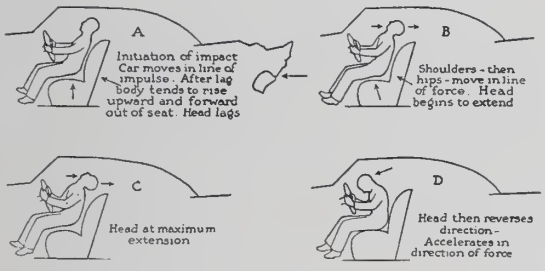
While the momentum of one vehicle is transmitted as force to the other there is a time lag on the part of the occupant. Following this lag, the injured motorist moves as though he were independent of the vehicle. After the vehicle has completed its acceleration, the victim's hips, shoulders and head are accelerated in that order. As pointed out by Marsh and Moore[4] the head and neck, being above the protection of the seat, are vulnerable to violent extension and flexion, the two components of true whiplash injury.

As a result of impact, in the rear end collision, the head and neck of the occupant of the struck vehicle lag behind the center of impulse transmitted from the striking vehicle to the trunk and body. (Figure 1a). The body is set in motion (Figure 1b) in the direction of the transmitted force while the head and

*Presented before the New Jersey Orthopaedic Society, Hackensack, April 11, 1959.

1. Hall, H. B.: Minnesota Medicine, 41:473 (1958)
2. Abel, M. S.: Journal of Bone and Joint Surgery, 40A:234 (1958)
3. Severy, D. M., Mathewson, J. H. and Bechtol, C. O.: Canadian Services Medical Journal, 11:727 (Nov. 1955)
4. Marsh, C. L. and Moore, R. C.: American Journal of Surgery, 93:623 (1957)

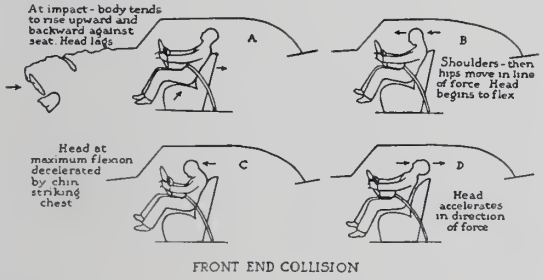
neck are forcibly hyperextended. As the impact continues, the head and neck reach the point of maximum hyperextension (Figure 1c). Then the direction of motion of the head and neck is reversed (Figure 1d). Motion proceeds in the new direction until the maximum in that direction is reached, when, again the direction is reversed. This, in effect, causes the unfixed head and neck to oscillate back and forth, in accordance with the velocity of the impact, due to the high "loading" or whip-like leverage force.



REAR END COLLISION

Figure 1.

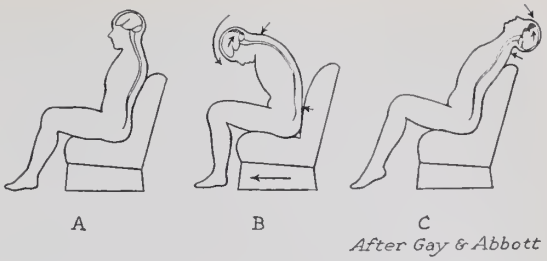
In a front end collision, generally where there is some restraint, such as a seat belt, the mechanism is the same except that the sequence of events is reversed (Figure 2).



FRONT END COLLISION

Figure 2.

Oscillation occurs in an anterior-posterior plane when the blow is from the front or rear, whereas it is in a lateral or oblique plane with a broadside or glancing blow. The earlier concepts of Davis,[5] Gay and Abbott,[6] and Lipow,[7] as to the exact sequence of motion are contrary to physical law.



After Gay & Abbott

Figure 3. Earlier concept of the mechanism of rear end collision.

Lack of awareness or insufficient time for defensive reflex on the part of the injured is necessary to prevent fixation of the controlling musculature. When there is any degree of forewarning, defensive reflexes are set up causing a variable degree of splinting. Splinting, in turn, causes the head to move more uniformly with the trunk and reduce head oscillations and, consequently, the degree of injury.

The stresses and strains of acceleration and deceleration produce a complex set of disturbances of the head and neck which may be divided into the cerebral, the cervical and emotional effects. In the rear end type of impact, the head is suddenly extended, the violence of which lashes the brain against the frontal area of the skull (Figure 4a) upon deceleration. Then, as flexion proceeds and is abruptly halted, against the occipital region (Figure 4b). According to the violence, concussion re-

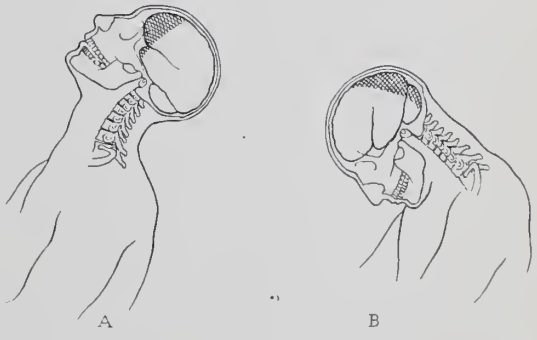


Figure 4. Cerebral effects of rear end collision.

5. Davis, A. G.: Journal of the American Medical Association, 127:149 (Jan. 20, 1945)

6. Gay, J. R. and Abbott, K. H.: Journal of the American Medical Association, 152:1698 (Aug. 29, 1953)

7. Lipow, E. G.: Southern Medical Journal, 48:1304 (Dec. 1955)

sults. The brunt of cervical injury is sustained by the soft tissues. Of these, the cervical spinal ligaments (ligamentum nuchae, ligamentum flavum, interspinous, supraspinous, anterior longitudinal, posterior longitudinal) and muscles (especially trapezius) sustain the greatest damage as they absorb the shock of repeated oscillations. More vital structures, such as the spinal cord and nerve roots and the vascular tree may be injured before the protecting muscles have an opportunity to react. Subluxation, dislocation, or fracture may occur. The intervertebral discs may be injured but the incidence is low (Jackson[8] and Watts[9]). No instance of rupture has been noted in this series. Secondary to injury to the head and neck, the shoulders, upper extremities, dorsal spine and lower back may become involved. Most often, there is no visible external evidence of injury. The exception is due to the head striking such objects as the dashboard, wind-shield, or rear-vision mirror. Emotional changes may develop within minutes of the accident, become increasingly more evident and fixed with the passage of time until they approach the psychoneurotic category.

PATHOLOGY

DISCUSSION of the pathologic changes must be based largely upon clinical observation. The supporting evidence of fresh autopsy studies is rarely available since fatalities are generally secondary to some other primary cause (skull fracture, heart, etc.). Gershon-Cohen[10] and his associates' studies of cadaver material are not entirely comparable to the changes seen in the living. Russell[11] points out that there is a sudden stretching of joint capsules, ligaments, muscles and nerve roots resulting in tearing of tissues with resultant hemorrhage and edema. The subsequent organization of hemorrhage and healing terminates in scar tissue with chronic fibrositis and loss of elasticity the ultimate result.

Subluxations and fractures may occur, though infrequently, in the more severe cases. They are exposed with difficulty and may not be evident on routine x-rays. Since the lower cervical spine is the most mobile, the pivotal point of the "whip" is at the level of the fourth, fifth and sixth cervical vertebrae, as demonstrated by Davis.[5] Thus these vertebrae are more susceptible to damage. Injuries at higher levels are likely to be more intractable, according to Mayfield and Griffith.[12] They frequently involve the second cervical nerve root and the greater occipital nerve due to the mobility between the atlas and the axis and the lack of posterior protection by the pedicles and facets.

Intervertebral disc injuries have not been common, in my experience, but some authors[6] report an incidence as high as 26 per cent.

Nerve roots may be momentarily and violently compressed without actual disc rupture in which case symptoms have an abrupt onset. On the other hand, the initial hemorrhage and edema involving the injured tissues often is sufficient to slowly compress the cord and/or nerve roots. Such would account for the delayed radicular symptoms in the absence of fractures or disc lesions.

Spasm and limitation of motion is simply a protective mechanism, as occurs in a fracture, but may be due to injury of the spinal accessory nerve producing spasm specifically of the trapezius and sternomastoid muscles.

SYMPTOMS

THE patient, subjectively, may not be aware of injury initially. Often, he is able to get out of his car and discuss the accident. He may feel "shaken up," mentally confused, dazed, or observe minor disturbances of equilibrium. There may be a momentary lapse of consciousness. These complaints are generally the re-

8. Jackson, R.: Dallas Medical Journal, 35:139 (1949)

9. McIntire, R. T., *et al.*: Journal of the International College of Surgeons, 28:54 (1957)

10. Gershon-Cohen, J., Budin, E. and Glauser, F.: Journal of the American Medical Association, 155:560 (June 5, 1954)

11. Russell, L. W.: Journal of the Florida Medical Association, 43:1099 (1957)

12. Mayfield, F. H. and Griffith, J. C.: Journal of the Michigan State Medical Society, 56:1142 (1957)

sult of mild concussion. In more severe cases, loss of consciousness may be prolonged. Headache or stiffness of the neck is usually the first persistent complaint. Either, or both, may be evident shortly after the accident but most often do not appear until later in the same, or upon the following day. It is not unusual for the patient to awaken the next day with these complaints. The headache may be frontal or occipital. Frequently, it seems to have its origin in the occipital area and radiate forward to the frontal and parietal areas. Most often it is unilateral. There may be accompanying ocular symptoms such as pain behind one or both eyes with blurring of vision, loss of accommodation, double vision, "spots before the eyes" and sensitivity to light. Twitching of the eyelids is not uncommon.

Stiffness of the neck is, with headache, one of the two most common complaints. It develops within the first twenty-four hours to a point where it is predominant. Most often, it begins as a mild aching sensation in the midline in the region of the nuchal ligament with radiation to the occiput. Later, the pain becomes more severe; spasm develops and there may be a pulling or cracking sensation upon motion. At this stage, minor disturbances in equilibrium may be supplanted by weakness, dizziness and a feeling of faintness. The patient may become more restless and irritable as he develops pain. Restlessness, irritability, and dizziness are common complaints. Pain may involve the occipital region of the skull, the mastoid process, the lower cervical and/or the upper dorsal spine, the rhomboid muscles, the vertebral margins of the scapulae, the shoulder girdle particularly the upper trapezius fibers. There is generally a background of dull, aching constant pain with exacerbations of more sharp, severe nature. The patient may observe a feeling of heaviness of the head so that he is compelled to support it with his hands, or rest it against the back of a chair, or simply recline. Some patients notice difficulty in swallowing. As the condition goes on stiffness of the neck gives way to actual limitation of motion with increasing difficulty in turning or twisting the head. Movement aggravates the pain. Pain, with sensory changes, may involve one or both upper extremities. Any, or all, of these symptoms may become more severe and may persist from a few days to a year or more.

As the situation becomes prolonged, and the condition becomes more chronic, the patient becomes more apprehensive concerning the question of recovery. He becomes more irritable and impatient and begins to lose interest in his work. As he becomes increasingly preoccupied with himself, his power of concentration is diminished, insomnia develops and he becomes quite depressed. He fatigues readily and suffers from lack of incentive. When litigation is involved, as so often it is, all of these conditions are accentuated.

PHYSICAL FINDINGS

If examination is undertaken within an hour or two following the accident the findings are generally few. There may be little evidence of injury other than slight spasm or tenderness of the paravertebral cervical muscles. But, 4 to 24 hours later, the patient is holding his head in a more or less fixed position. There may be forward, posterior or lateral tilt. He is unwilling to make abrupt movements, tending to change position slowly or cautiously. There may be tenderness on pressure over the occiput and/or over the mastoid processes. Additional tenderness may be noted, on deep palpation, over the transverse and/or spinous processes of the cervical or upper dorsal spine, over the supraspinatus fossae or along the vertebral margins of the scapulae.

Spasm of the posterior and lateral cervical muscles is evident. The trapezius splenii, scaleni and sternomastoid muscles are most frequently involved. There is limitation of neck motion. Forced motion of the head and neck provokes pain especially at the extremes of motion. Downward pressure upon the skull with the head tilted to the more affected side may elicit severe or local and/or radiating pain,[13,14] whereas extension or traction relieves the pain.

Paresthesias are frequently noted over the

13. Jackson, R.: AAOS lecture series on "Tho Cervical Syndrome," 10:65 (1953)

14. Spurling, R. G. and Scoville, W. B.: Surgery, Gynecology and Obstetrics, 78:350 (1944)

lateral aspects of the shoulder and arm and over the dorsal aspect of the forearm. The fingers may be involved according to whether the radial, median or ulnar components are involved.

Weakness at the shoulder due to involvement of the deltoid and at the wrist due to involvement of the extensors may occur. Loss or weakness of grasp is the most frequent motor change resulting from weakness of flexion and extension of the fingers.

Disturbances in equilibrium often are evident at the time of, or shortly after, the accident. Generally, this is a transient finding which disappears within a few days. However, in one case loss of equilibrium persisted for a period of some two months accompanied by aphasia and loss of memory which are now clearing up only after a period of some eight months.

In subluxations, the findings are those seen with subluxation from any cause. The typical position of the head and neck is with the head tilted away from the involved side, the chin rotated toward the same side and the neck maintained in some degree of flexion.

X-RAY FINDINGS

X-RAY studies should be made as soon as the patient's condition warrants. If serious cord or root damage is suspected, they should be deferred until a satisfactory clinical survey can be made. Films should be made in the open mouth, antero-posterior, oblique and lateral projections. Lateral views should be made in neutral, flexed and extended positions.

The most frequent finding is loss of the normal cervical lordosis due to spasm of the paravertebral muscles. This is seen in the absence of fracture, subluxation or dislocation. However, its presence is sufficiently abnormal to warrant establishment of the diagnosis of flexion-extension injury when consistent with the clinical findings. All too often, the true nature of the condition is minimized when more definite injury is not in evidence.

Lateral views aid in the visualization of loss of cervical lordosis, narrowed intervertebral spaces, anterior or posterior subluxations, fractures of the spinous processes and bodies of the vertebrae, pre-existing osteoarthritis with sclerosis, osteophytic lipping and bony bridging, congenital abnormalities as well as specific diseases of bone.

The oblique views will demonstrate primarily the condition of the intervertebral foramina, the patency of the foramina, the presence or absence of encroaching spurs upon or within the foramina. This may give a clue as to the level and degree of root involvement.

The antero-posterior views demonstrate the presence or absence of normal alignment of the vertebrae, the direction of and the amount of tilt or distortion in the instance of subluxation or fracture. Osteophyte production, narrowing of the intervertebral spaces and congenital abnormalities may also be revealed.

Open mouth views are desirable. They demonstrate the atlas and axis better than routine antero-posterior views. Fractures of the odontoid process may be visualized. The intervertebral space between the first and second cervical vertebrae may be more clearly shown.

Myelograms should be reserved for cases where cord or disc pathology is suspected.

Occasionally a soft tissue bulge in the form of a rounded swelling between the anterior aspect of the cervical spine and the esophagus can be shown. This, in Compere's[9] opinion, represents a hematoma at the site of the tear of the anterior longitudinal ligament. This may account for the difficulty in swallowing noted in some cases.

TREATMENT

TREATMENT must be provided, according to the individual requirements of the case, either on an ambulatory basis or as an in-patient in the hospital. Analysis of the injury by the family doctor or initial treating physician is, therefore, essential to a good end-result. In the early stages (first 4 to 12 hours) the complaints may be so minor and the findings so meager as to make the decision difficult. In some instances, a good deal of persuasion may

be necessary to keep the patient under observation.

If the patient is confused or dazed, sedation ought to be withheld until further observation is possible. He should be watched for evidence of head injury or fracture. As in all head injuries, opiates should be avoided. However, if he is simply apprehensive some form of sedation should be employed.

Ambulatory Treatment—In the milder cases, bed rest is not essential. Rest periods during the day may supplement ordinary sleeping hours in the prevention of fatigue. The cervical contour pillow, introduced by Jackson,[8] aids in avoiding further muscle strain. A cervical collar will provide support and protect against increased muscle spasm. At home moist heat (hot towels, hot showers) is readily available and useful in relieving spasm. Hot wet packs preliminary to traction may be effectively administered in the office. Traction is beneficial either through the use of motorized equipment in the office or as manual portable apparatus at home. Muscle relaxants, by mouth, are of limited value alone; but, in conjunction with the tranquilizers both are quite effective in relieving muscle spasm, allaying apprehension and providing sedation. Thiamin chloride and Vitamin B complex appear to have some virtue in the reduction of nerve irritability. The injection of localized areas of muscle tenderness and "trigger points" with procaine often affords some relief. When radicular symptoms involve the upper extremity, stellate ganglion block may prove beneficial. Because of the protracted nature of "whiplash injury," narcotics should be avoided or used sparingly. The synergistic effect of one drug with another (aspirin with codeine, chlorpromazine (Thorazine®) with morphine) may aid in reducing the total amount administered.

Hospital Treatment—The more severe cases should be hospitalized. These patients generally complain of severe neck pain or stiffness, excruciating headache, are emotionally upset or exhibit findings suggestive of fracture or other serious injury.

Bed rest, with a bed board, should be instituted and maintained at least until a careful study warrants change. Adequate analgesics, narcotics and sedatives must be given to control pain. Narcotics should be used judiciously with a view toward the long range aspect of the injury. When given every four hours, codeine or dextropropoxyphene (Darvon®) have proved effective. Caution should be exercised in the use of sedation since the barbiturates will further excite an emotionally disturbed patient. Providing the x-rays demonstrate no contra-indication (fractures, fracture-dislocations) cervical traction should be instituted. In contrast to traction in the upright position on an ambulatory basis, horizontal traction is more effective. It need not be continuous, rest periods at mealtimes and at intervals during the day enable the patient to cooperate more fully. The use of thiamin chloride and/or B complex as an adjunct to traction, minimizes headache, shortens the period of traction therapy and produces a feeling of well being. Muscle relaxants have been used with varied success. The tranquilizing drugs enhance the value of the muscle relaxants, reduce the requirement for analgesics, sedatives and narcotics and, therefore, are of great value. The antihistaminics, diphenhydramine (Benadryl®) and tripelennamine (Pyribenzamine®), also have a synergistic action with the muscle relaxants and may be employed. Procaine, every two or three days, injected into "trigger points" aids in reducing pain and spasm. Stellate ganglion blocks are more useful in the hospitalized case since generally the radicular symptoms are likely to be more pronounced. Amphetamine, in small amounts, helps to counteract depression. As the patient improves, he is measured for and fitted with a collar and gradually made ambulatory. Then, treatment may proceed on an ambulatory basis.

In more protracted cases, the combined efforts of the orthopedist, the neurosurgeon and the psychiatrist may be required. Subluxations, fractures, and fracture-dislocations must be treated in the conventional manner. In such instances, following reduction, immobilization in plaster may be desirable. Some skeletal injuries may warrant cervical spinal fusion.

In older individuals, where pre-existing osteoarthritis complicates the picture, x-ray therapy may be used as an adjunct to the or-

dinary measures such as salicylates, physiotherapy and immobilization.

If there is persistent radicular pain, not relieved by traction, local and stellate-ganglion blocks, further investigation including myelograms may be necessary. Consideration should be given to the exploration for and removal of an offending disc. Mayfield and Griffith [12] found that the second cervical root was frequently involved and that relief was afforded by section of the sensory root.

From the psychiatric standpoint, the initial symptoms of confusion and disturbance in equilibrium may be supplanted by weakness and dizziness and, later, by restlessness and irritability. As the condition becomes more chronic, the patient becomes more irritable, more impatient, more pre-occupied and more depressed. As he becomes more apprehensive and fearful for his recovery he may become very "upset" emotionally, susceptible to suggestion, even to the point of hysterical fixation and lapse into a true psychoneurosis. The time for accurate diagnosis, adequate treatment and reassurance has then passed. Psychotherapy is required.

PROGNOSIS

THE prognosis depends upon (1) degree of injury; (2) early diagnosis and institution of treatment; (3) the patient's willingness to accept reasurrance that he will recover; and, (4) early settlement of pending litigation.

The injury may include severe concussion, fracture, fracture-dislocation or disc injury in a small percentage of cases so that recovery would be naturally somewhat retarded. However, early recognition of the condition and prompt institution of adequate treatment will bring about a satisfactory ultimate end-result in the majority of cases. Reassurance and sympathetic understanding will enable most patients to weather emotional storms and fearful apprehension so long as they are given the hope that they will eventually recover.

Recovery may be delayed, postponed or prevented by impending legal action. Enthusiastic aspirations for a sudden bonanza may erect a barrier not easily hurdled. Early disposition of suit is therefore desirable. Gotten [15] found that only six per cent of patients sought further treatment after settlement.

15. Gotten, N.: Journal of the American Medical Association, 182:865 (Oct. 27, 1956)

SUMMARY

1. Flexion-extension injury of the head and neck is becoming more common.
2. Rear end collision is the usual cause. Front end accidents, glancing or broadside blows may also produce it.
3. The head and neck are vulnerable since they are above the protection of the seat.
4. The injury involves soft tissue (sprain) but associated subluxuations, fractures, fracture-dislocations, disc and nerve root damage may occur.
5. Headache and stiffness of the neck are the most common complaints.
6. Spasm, limitation of motion, local tenderness are the most frequent findings.
7. Loss of cervical lordosis is the most constant x-ray finding.
8. On the basis of the history of type of accident alone, the patient should be persuaded to remain under observation for twenty-four to forty-eight hours at least.
9. Understanding and early treatment may shorten recovery time and prevent psychoneurosis.
10. Treatment is divided into ambulatory and hospital phases.
11. Prognosis depends upon degree of injury, early diagnosis, treatment and settlement of litigation.
12. Persuasion to accept treatment and reassurance is often the key to a good end-result.

144 South Harrison Street

Martin Green, M.D.

Atlantic City

Coffee As a Food Allergen

Saying anything against coffee sounds practically unAmerican. But, as Dr. Green points out, there is such a thing as coffee sensitivity and it is the doctor's job to know this, detect it, and treat it.

When a food is used in quantity by the general population, there is always the possibility that certain individuals will develop an allergy to that food. The American public consumes increasing amounts of coffee, averaging 16 pounds per person a year since World War II. Americans actually drink over two and one-half cups of coffee per person daily. Eighty percent of the world's coffee crop, (over 2,500,000,000 pounds in 1956) is consumed in the United States. The opportunities for coffee to act as an allergen appear to be infinite. Consequently, it is surprising to note the scanty information on coffee sensitivity in the medical literature.

Coffee is part of the American diet because of both its flavor and its stimulating effect. The flavor is due to the aromatic oils dispersed throughout the brew. Caffeol is the most important of these oils. Caffeine is responsible for the stimulating effect. Some of the caffeine is extracted when the coffee is brewed. An average cup of coffee contains 100 to 120 milligrams of caffeine.

In the past, there was fear that allergies might develop to some of the coffee adulterants such as beans, carrots, and peas. This danger has been reduced by the Pure Food Law. Chicory, though, is still widely used as an addition to coffee to improve the flavor. The general classification of coffee sensitivity includes coffee intolerance, caffeine intolerance, allergy to coffee, and allergy to caffeine. One or more of these reactions may occur in the same individual. Coffee intolerance is the almost immediate gastritis that develops when the coffee is ingested. This is *not* an antigen-antibody reaction, but simply an inability of the gastric mucosa to tolerate coffee. Caffeine intolerance occurs in coffee drinking individuals who are abnormally susceptible to the ingestion of the drug. The symptoms are an exaggeration of the characteristic pharmacologic action of caffeine. True allergy to coffee is probably the result of an antigen-antibody reaction. The aromatic oils that create the pleasant flavor are possibly the responsible allergens. Allergy to caffeine, within the limits of the definition of drug allergy, does occasionally occur. Drug allergy is a noncharacteristic reaction to an amount of drug nontoxic to a normal individual.[1]

Gutmann[2] states that hypersensitivity to coffee is infrequent. One must differentiate allergy to coffee, to caffeine, and to additives. Rinkle[3] notes that among corn, wheat, milk, egg, potato, orange, beans, beef, tomato, legumes, and pork, coffee ranked about equal with legumes and pork and behind the others

1. Boyd, W. C.: Fundamentals of Immunology, Ed. 3, New York, Interscience Publishers, 1950.
2. Urbach, E. and Gottlieb, J.: Allergy. Ed. 2, p. 312, New York, Grune and Stratton, 1951.
3. Rinkle, H. J.: Food Allergy. Springfield, Charles C Thomas, 1951.

in allergenicity. He describes a number of cases based on coffee allergy. Rowe [4] reports that several skin reactions have been obtained to coffee, though marked clinical reactions are a little hard to differentiate, from those due to the stimulating effects of caffeine. In one patient of his, diarrhea always resulted from drinking a cup of coffee. Hansel's only comment [5] is that allergic symptoms may result from the adulterants in coffee rather than from coffee itself. A number of articles [6] refer to coffee as an inhalant occupational disease.[7] There are very few, if any, reports of coffee as a food allergen in the American or English literature, other than the meager descriptions in text books.[8]

Of the five cases reported in this paper, four represent true allergic manifestations to coffee. Patient number 1 manifested her allergy by a severe migraine. The second patient complained of gastro-enteritis and headache only during the pollinosis season. The third noted gastro-enteritis, malaise, headache, and allergic rhinitis; and the fourth complained of widespread urticaria. These four cases, more or less, cover the gamut of symptoms caused by food allergies. Rowe [4] states that coffee can be responsible for migraine, asthma, gastrointestinal complaints, cutaneous and other manifestations. Gutmann [9] observed itching, urticaria, angioneurotic edema, intestinal spasms, diarrhea, and rhinopathy. Rinkle [3] reports headache, shoulder aching, and asthma, in one case of coffee sensitivity. Migraine is an occasional symptom of food allergy. McNaughton [10] writes that "occasional relationship has been found between food idiosyncrasies and migraine, though special elimination diets have not often proved helpful in spite of claims of enthusiastic allergists." Graham,[13] in his textbook *Treatment of Migraine* does not even mention allergy as a factor. Unger,[11] on the other hand, remarks that two of his cases of migraine were probably due to coffee. As Vaughn and Black [12] state "one may be allergic to coffee, reacting with any of the characteristics of food allergy."

4. Rowe, A. H.: Food Allergy. Phila., Lea and Febiger, 1941.
5. Hansel, F. K.: Clinical Allergy. St. Louis, C. V. Mosby Co., 1953.
6. Brunn, E.: Nord. Med., 58:1963 (December 19, 1957).
7. Figley, K. D. and Rawling, F. F. A.: Journal of Allergy, 21:545 (November 1950).
8. Personal Communication: Medical Documentation Service, Library of College of Physicians of Philadelphia.
9. Urbach, E. and Gottlieb, J.: Allergy. Ed. 2, New York, Grune and Stratton, 1951.
10. Meakin, J. C.: Practice of Medicine. Ed. 6, St. Louis, C. V. Mosby Co., 1944.
11. Unger, A. H.: Annals of Allergy, 13:523 (Sept.-Oct. 1955).
12. Vaughn, W. T. and Black, J. H.: Practice of Allergy. Ed. 3, St. Louis, C. V. Mosby Co., 1958.
13. Graham, J. F.: Treatment of Migraine. Boston, Little and Brown, 1957.

CASE ONE

A 39 year old woman had a prolonged history of migraine extending over eight months. At the suggestion of her physician, and only as a last resort, she was referred for an allergic survey. The first portion of this case report is a transcript of a portion of the letter from the referring physician.

"This is the first University Hospital admission for this lady. She dates her present difficulty to an attack of poison ivy dermatitis five months previous to admission. Since then she has had intermittent periods of low-grade fever, weakness, malaise, frontal headaches, nausea, sore throat, nasal blockage and prostration. Two similar episodes have occurred, one five years ago, and another five years previously.

"Physical examination was completely negative. Diagnostic survey including evaluation of the thyroid, liver, intestinal tract, lungs, heart, gall bladder, and pelvic organs, was completely negative."

The referring physician continues, "On more careful analysis of her history I became convinced of the fact that she has, among other things, a very definite migraine pattern."

She had a constitutional reaction to coffee when skin tested intradermally with a 1 to 10 dilution of the usual concentrations used for intradermal testing (Jefferson Medical School extracts). This reaction consisted of shock characterized by an increased pulse rate, lassitude and weakness, extreme nausea, and a dropping blood pressure, followed by the development of severe migraine. The symptoms other than the migraine and gastroenteritis were relieved by epinephrine. Her skin tests to coffee were markedly positive. The patient said that she was a continuous coffee drinker, particularly during the eight months that her migraine had become so incapacitating. She drank coffee to "keep herself going." Her coffee sensitivity was further confirmed by the ingestion of a group of colored capsules which, in total, contained one heaping teaspoonful of soluble coffee. These capsules were swallowed immediately following the drinking of one and one-half cups of hot water. The patient was under the impression that she was swallowing capsules of granulated

sugar as she had done one hour previously. All the symptoms of migraine and gastro-enteritis recurred within five minutes of the swallowing of the coffee capsules. At a later date all of her symptoms were again reproduced by drinking decaffeinated coffee, tea, and Coca Cola®.

Her migraine was typical and accompanied by nausea, vomiting, and prostration. During the eight months of her illness, these symptoms were continuous because of her constant drinking of coffee. She recovered completely when coffee was removed from her diet. This is a case of true coffee allergy.

CASE TWO

A woman had gastro-enteritis and headache, occurring only during the period of pollinosis. She was able to drink five cups of coffee daily at any time of the year other than the ragweed season. During the ragweed season she had symptoms of pollinosis manifested by itching of the eyes, allergic rhinitis, sneeezing, and irritability. Even one-half cup of coffee at this time would induce a severe headache and abdominal cramps, followed by diarrhea. Symptoms of pollinosis improved remarkably on perennial treatment for ragweed, dust, and grasses. In spite of this improvement, her coffee sensitivity continued to be accentuated during the ragweed season. She was markedly positive to the intradermal test for coffee.

CASE THREE

This is a case of allergic rhinitis based on multiple food sensitivities. She also complained of hay fever, occasional attacks of asthma, malaise, and headache. When seen in late October the only abnormality noted on physical examination was a thick postnasal drip, and a red and inflamed nasal mucous membrane.

Skin testing for inhalants revealed mild sensitivity to ragweed pollen and alternaria, and marked sensitivity to dust. Skin tests for foods revealed sensitivity to tomato, cocoa, clams, spinach, banana, canteloupe, strawberry, and wheat. She was taken off all of these foods and her allergic rhinitis disappeared. In our weekly conferences she noted that when she remained on her elimination diet and drank coffee there was recurrence of her symptoms. She developed nasal coryza, discomfort at the pit of her stomach, fatigue, and headache. Coffee was then added to the list of suspect allergens.

She was skin test negative to coffee. When tested with coffee capsules (similar to the procedure in case one) all of the symptoms were reproduced. She was given 150 milligrams of caffeine by mouth without developing any symptoms.

Cases Two and Three represent food allergies that might have resulted from any food. That they resulted from coffee emphasizes the ability of this beverage to act as an allergen and produce typical food allergic manifestations.

CASE FOUR

A man had urticaria following ingestion of coffee. He was skin test sensitive to coffee, wheat and rye. On a wheat-free and rye-free diet he did well. In our weekly conferences, he said that in the future he intended to partake of coffee breaks at his office. Within one hour of the first one there was a tremendous exacerbation of the hives involving all of the surfaces of the body, including the face. This happened daily. Heeding my advice, he discontinued these coffee breaks for two weeks, remaining on his wheat and rye-free diet. His hives disappeared completely.

He remained on this wheat, rye, and coffee-free diet for eight months. He then began to drink coffee without recurrence of hives. He was placed on four cups of coffee daily for one week. He was also given the coffee capsule test. No hives developed as a result of these tests. He has remained on his rye and wheat-free diet, and has been absolutely free of hives. He now partakes of coffee in moderate amounts. He has apparently developed a tolerance to coffee.

CASE FIVE

This is a case of possible caffeine intolerance. A woman had stopped drinking coffee five years ago because of palpitation of the heart and fatigue following coffee ingestion. Recently she stopped smoking and began to drink coffee in the afternoon. She noted immediately that her chronic constipation was relieved by a loose, watery stool. She now drinks coffee in the morning to induce a loose stool; but she also develops palpitation of the heart.

She discontinued coffee for four days. Her symptoms (other than constipation) disappeared. With the first cup of coffee her difficulties appeared in a markedly exaggerated form. She continued the routine of coffee every morning and within two days the palpitation and fatigue were masked sufficiently so that they were similar to the symptom complex before she discontinued coffee. All symptoms were reproduced when she swallowed 150 milligrams of caffeine. The constipation was not relieved on three occasions when she drank a cup of decaffeinated coffee, although mild coryza and fatigue did occur.

Four cases of probable coffee sensitivity and one of caffeine intolerance are evaluated. In all five cases a cause and effect relationship was indicated by the disappearance of the symptoms when coffee was withdrawn from the diet; and recurrence of symptoms when coffee was reintroduced. In two of the cases, hot water and soluble coffee in capsules were administered without patients

knowing that they were receiving coffee. In each instance the symptom complex was reproduced. In Case One, the intradermal testing with the dilute solution of coffee was sufficient to cause shock and reproduce all of the symptoms in their most exaggerated form. Three of the patients had markedly positive skin test to coffee, two of them were negative.

Rinkle [3] defines food allergy as a term used in reference to "Those foods for which it is possible to demonstrate a cause and effect relationship between the ingestion of a specific food and the production or accentuation of allergic symptoms. This relationship must not only exhibit specificity, but it must be demonstrated repeatedly upon every occasion when the tests are performed correctly." The four cases of coffee allergy (omitting the case of caffeine intolerance) fulfill these criteria.

SUMMARY

FOUR patients with allergy to coffee are presented. All have symptoms suggestive of food allergy. All showed a cause and effect relationship in that the symptoms could be reproduced by the ingestion of coffee. The only case that developed a tolerance to coffee was Number Four. When tolerance developed, it was impossible to reproduce the symptoms on the ingestion of coffee. One case of intolerance to caffeine is presented. The symptoms here could be reproduced when caffeine alone was administered.

Because of the greater amount of coffee ingested by Americans, and the use of coffee by many more people, coffee sensitivity is possibly on the increase. Physicians must be on the alert for coffee as a food allergen.

1922 Pacific Avenue

Enuresis

The incidence of enuresis is high: 20 per cent of children in a general pediatric clinic have been enuretic for some period of their lives. This is a symptom of organic (2 per cent) or emotional illness. Even the emotional group display signs and symptoms indicating a constitutional basis: the patients have small, irritable and easily responding bladders, and they are overexcitable children who are hard to control.

There are families in which bedwetting is considered normal. A common misconception is that emotionally caused enuresis is thought of in terms of loss of control: children who wet the bed repeatedly, in spite of extensive precautionary measures, often have excellent bladder control in the daytime, voiding only two or three times.

Therapy depends on finding the meaning and context in which enuresis is an expressive symbol. It may be the passive child's only weapon to get people mad; the jealous child's only means of drawing his mother's attention; or a regressive symptom in a phase of development—"These requirements of new adjustment are too hard for me; I go back to a much more comfortable time."

Enuresis may also have a "pleasure" basis, or it may be caused by the child's feeling of being helpless. Habit may also play a role.

The multiplicity of therapeutic measures arises from the fact that each has worked at some time or other. Drug therapy includes amphetamine (to promote *light* sleep), atropine (to dry the child up) and tranquilizers (to relieve acute anxiety). Diet therapy (low or high salt diet) works in some cases. Suggestive therapy that sometimes succeeds ranges from urethral dilation to the military method of putting two enuretic recruits in double-decker bunks without mattresses, turn and turn about in the top bunk.

The urologist should make sure that there are no organic causes before any therapy is chosen.

—Lourie, R. S.: *Clinical Proceedings of the Washington, D. C. Children's Hospital,* 15:175 (1959).

Bartholomew A. Ruggieri, M.D.

Montclair

The Front Line of Medicine: Pediatrics

Still unsettled is whether child guidance belongs to the psychiatrist, the pediatrician or the pedagogue—a word which, in its original Greek, means "child guide." Dr. Ruggieri here offers an eloquent plea for pediatric-centered child guidance.

The frustration and discontent of many pediatricians has been the subject of several articles in the recent medical literature. These negative reactions are caused by the fact that pediatrics is a field demanding long hours of "routine" work often not requiring their specialized skills and knowledge. Nor does this provide an income commensurate with the pediatrician's training and background. Going into group practice would not seem to be a good solution, since the pediatrician still would spend most of his time in work that can be well handled by the conscientious and well trained family physician who keeps up with the ever advancing horizons in this as in other fields of medicine. Thus, as an example, medicine has given us the means to treat most childhood (and adult) infections easily and completely—whether one be a specialist or a general practitioner. Obviously, in the care of children (as in the care of adults) there are a certain number of cases which present problems requiring the attention of a physician with specialized knowledge of a given field. As medical horizons broadened, this occasional but vital need of the family physician for a consultant with specialized knowledge was, historically, the setting in which today's multiple specialization first appeared. But, such cases which in this era of medicine require the services of a consultant are, in pediatrics (as, perhaps, in some other specialties), too few to satisfy the needs of all of us who are in this specialty. What can be done?

It is in the field of *developmental pediatrics,* physical and particularly emotional, that the great challenge—and the great opportunity—lies. It is into this area that one of the major historical aims of pediatrics, preventive medicine, can be extended—and, indeed, requires extension if our specialty is to go along fully with medicine's current concept of treating the whole person, mind and body, as a unit. Actually, beyond the expected desire to keep their children physically healthy, parents today are looking more and more for information and guidance on questions involving primarily the emotional lives of their children and, as a necessary corollary, questions involving various interpersonal relationships, particularly those within the family, since each affects the other. As the physician who, they feel, is best trained and qualified to evaluate children from birth through high school age, it is to their pediatrician that parents often turn for such help.

The practicing pediatrician will agree, as he reviews his typical office day, that many of the questions he is asked (if he can find the time to listen to the mother) fall into this category: "Doctor, Tommy still sucks his thumb. Is it anything I should worry about? What should I do?"; "Ever since we brought the baby home from the hospital, Mary has

been soiling herself again and is always into something she shouldn't be doing. She's become a terror around the house. It upsets me, and, I don't mind saying, it sometimes makes me good and mad. What happened? What can I do?"; "As you know, Doctor, Johnny goes into the hospital to have his tonsils out next Tuesday. How should I tell him?"; "Sarah is overweight, always eating. Can you give me a diet she'll stick to?"; "I had a conference with the teacher last week. My husband and I were shocked. Robbie has been doing poorly in school. If his work doesn't pick up, he'll be left back. We know—and the teacher agrees—that Robbie is a smart boy. He has the ability to put forth good work, but he isn't doing so"; "Richard has stopped eating completely. He ate well the first one and one half years of his life, but now—. We're worried. What can we do? We've tried everything. Won't it affect his health? He must eat!"; "Doctor, she's just resisting bowel training. I know it"; "My Roger won't leave me. What can I do when he starts school this fall?"; "Doctor, we both appreciate the time you've taken with us. We feel better now that we know something about this temporal lobe epilepsy and what can be done for it. But what shall we tell Sally—and her friends?" Some of these questions refer only to variations of behavior within the normal range; others point to the possible presence of various emotional aberrations.

THUS, although it is sometimes said that children do not have emotional problems and psychosomatic diseases, this statement is simply not true. Children do not live in an emotional vacuum. They are aware of the many nuances of feeling in their environment and respond accordingly, "good" or "bad," healthy or unhealthy. And these responses may take the form of psychosomatic illness (for example, duodenal ulcer, chronic ulcerative colitis, asthma, atopic dermatitis, "anorexia nervosa," headaches and obesity). With increasing frequency, the pediatrician meets questions and problems involving the emotions. To recognize them for what they are, the physician must thoroughly know his subject, not only those feelings which are openly professed (conscious) but also, more important in their myriad effects upon the patient, the many undercurrents of feeling (unconscious) operating beyond the awareness of the patient and his parents.

Too often, that which involves the emotions becomes the object of the misplaced solicitude of all sorts of self-styled experts. One can always get an opinion from a lay person based on his or her own casual experiences. Although such an individual would not expect to diagnose or treat a person with meningitis without adequate and carefully supervised training in the field, he does not hesitate to render a gratuitous opinion when a problem involving the emotions presents itself. Yet, it is only the physician, who, with training in all the branches of medicine, can look at the patient as a whole, the mind as well as the body, recognizing the interdigitating effects of each and aware that, most often, one cannot neatly (and artificially) separate one from the other. Such a physician would not put off the parent's honest questions with the facile and innocuous answers so common to the uninformed. He would not take the easy escape so commonly used: "He is only a child; he'll get over it." The hard fact is that the child, as we well know, does not "get over it"; a child (and the later adult) is the product of all the life experiences which have befallen him.

For example, during my own pediatric training, I spent additional optional time on child psychiatry, and I have taken further graduate training in dynamic psychiatry. I have many times had referred to me, for study, patients who had been diagnostic teasers for the physicians; my separate interviews with each of the parents and with the patient in the playroom set aside for this purpose have been useful to me in establishing the etiologic role of the emotions in the child's presenting complaint and in delineating the psychodynamics. My work thus becomes useful and interesting and is not confined to "routine." And, perhaps most important to the present discussion, I am performing a service in an area of medicine in which the need is great and the numbers of those trained to fill that need is small.

Why do not more pediatricians go further into this area? If necessary, might they not take additional training in this branch of medicine during their pediatric fellowships and residencies? Cannot they then better fulfill their historic role as consultants on childhood problems and illnesses (organic and emotional) for the family physician; and cannot they then spend a much greater proportion of their time acting as consultants? Then the general pediatrician may again be regarded as a true specialist performing a much needed and unique service. And he need no longer run an "assembly-line" practice, seeing large numbers of patients each day; he can thus get to know his patients, not as cases to whom this or that procedure is scheduled to be done, but as individuals with highly individual problems and needs that benefit from his particular attention and training. And in return the pediatrician will again have the full professional satisfaction that his early predecessors received so abundantly.

72 South Mountain Avenue

Nylon Mesh in Hernia Repair

Autogenous grafts of fascia, skin and metallic or synthetic meshes are popular means of prosthesis in hernia repair. Recurrences have been observed in cases in which these prostheses were used. Recurrences appear to be due to excessive tension, infection, insufficient amounts of tissue transplanted or fragmentation of metallic meshes.

Whole skin for hernia repair is useful since it contains many fibrous elements but if accidentally displaced before it is solidly healed it may become necrotic or it may roll on itself and form a dermoid cyst. A cutis graft, prepared by dermatome removal of upper layers of skin, will avoid some of the later complications.

Tantalum mesh breaks up in the abdominal wall. This occurs during the first year following implantation as the scar tissue associated with it begins to soften and thin out. Nylon mesh may eliminate some of the difficulties although in case of infection it will be rejected by the tissues as a foreign body.

—Smith, Robert B.: Archives of Surgery, 78:868 (1959).

Postoperative Convalescence

Do sick leave benefits have any effect on the length of convalescence after an operation? No, according to *Patterns of Disease,* a Parke, Davis and Company publication. In fact, *Patterns* reports, "The most important single factor in determining the duration of total convalescence after uncomplicated surgery" is the opinion of the individual physician. "Factors such as age, income and sick leave benefits," the publication adds, "seem to have little or no effect on length of convalescence."

A wide disparity of opinion exists among physicians concerning the lengths of convalescent periods after operations. Generally, specialists make shorter estimates of the convalescence needed before a patient returns to work than do general practitioners. *Patterns* revealed that with appendectomies, professors of surgery estimated an average of 12 days convalescence before returning to light work and 23 days before a return to heavy work. For the same operation, general practitioners estimated an average of 15 days convalescence before returning to light work and 31 for heavy work.

L. J. Denson, M.D.*

W. R. Thompson, M.D.*

Hackensack

A New Salicylate Therapy for the Treatment of Arthritic Diseases

Despite new advances in steroids, salicylate therapy remains the backbone of treatment in managing arthritis. The problem is to avoid gastric irritability and to provide medication which will continue its beneficial effects during intervals of non-treatment. The authors have found good results with a new salicylate compound.

In the treatment of arthritic diseases, rest, diet and physiotherapy are fundamentals in successful management. The drug armamentarium is extensive, but unfortunately contains no specific remedy.[1] The drug of first choice is salicylate. Generally, in osteoarthritis no other drug is required. In a two-year study of early cases of rheumatoid arthritis, the response to salicylates was found to be not significantly different from the response to cortisone.[2] It has become important to recognize the risks incurred with long-term use of the adrenal steroids as weighed against theoretical advantages.[3] Of the three analgesic-antiphlogistic drugs used in arthritis (salicylate, phenylbutazone and corticosteroids) the salicylates are the least hazardous.

The classical symptom of salicylism is tinnitus, which serves as a signal to stop administration temporarily and to reduce dosage on resumption. Idiosyncrasy to salicylate may be serious, but fortunately it is rare. Gastro-intestinal bleeding is not uncommon, particularly in patients with peptic ulcers. Hypothrombinemia rarely plays a significant role. The gastro-intestinal bleeding is a severe manifestation of local irritant effect on susceptible mucosa. Mild to severe gastro-intestinal distress is a fairly frequent complaint with salicylate therapy. The gastric intolerance increases with the larger doses and prolonged therapy required in arthritis.

Simultaneous administration of buffering agents has been reported of no value in decreasing gastric intolerance.[4] With the enteric-coated products,[5] the therapeutic efficacy may be sacrificed because of poor absorption.[6]

Gastric intolerance prohibits salicylates in

*From the Arthritis Out-Patient Department of the Hackensack Hospital.

1. Garren, M. G.: Med. Times, 87:207 (1959).
2. Joint Committee of the Medical Research Council and Nuffield Foundation. Brit. Med. J., 2:695 (1955).
3. Lockie, L. M.: Journal of the American Medical Association, 170:1063 (1959).
4. Batterman, R. C.: Postgraduate Medicine, 25:97 (1959).
5. *Editorial*: Salicylates in Arthritis. South. Med. J., 49:304 (1956).
6. Canadian Department of National Health and Welfare, Ottawa: Availability of Drugs in Tablets. Canad. Med. Assoc. J., 76:140 (1957).

some arthritic patients and may preclude adequate dosage in others. However, perhaps the most important disadvantage of salicylates in arthritis is the inadequate relief of pain provided, using a usual dosage. This deficiency is not due to the inefficiency of salicylates as analgesics, nor to the development of tolerance. As pointed out by Bayles and Tenckhoff,[7] by Batterman[4] and by others, it is due to the rapid elimination of salicylates and failure to maintain adequate salicylate levels.

Complete relief may be attained with *adequate* doses of salicylate taken at four-hour intervals; but it is inconvenient to take this at night. If the patient does not take it at night, his pain recurs in the morning because of the elimination of the drug during the night hours. Readministration of salicylate on arising restores analgesia, but the recurrence of pain at night or each morning can be a source of great dissatisfaction with the therapy.

The salicyl ester of salicylic acid is notable for its insolubility in water and acid environment. Hence, it does not cause chemical irritation of gastric mucosa. After ingestion of salicylsalicylic acid, salicylate appears in the urine more slowly and for a more prolonged time than after aspirin or sodium salicylate.[8] The total salicylate finally excreted is only 15 per cent less than that following aspirin, indicating its physiologic availability. The salicyl ester of salicylic acid provides more salicylate, weight for weight, than do the acetyl ester or the soduim salt of salicylic acid.

METHODS AND MATERIALS

An uncoated tablet† containing 500 milligrams of salicylsalicylic acid and 150 milligrams of acetylsalicylic acid (the latter to provide prompt analgesia) was clinically tested for gastric tolerance and ability to provide constant analgesia and relief of morning pains.

The study included 47 adult patients in an out-patient arthritic clinic. This included 32 cases of degenerative joint disease, 12 rheumatoid arthritis, two post-traumatic arthropathy and one of bursitis. Each diagnosis was established by symptoms and laboratory data. The cases were classified in accordance with the nomenclature of the American Rheumatism Association (Table I). Laboratory tests included sedimentation rates, before and after the treatment; complete blood counts and urinalysis, once a month and cephalin flocculation every three months.

Each patient was started on two salicylic acid-acetylsalicylic tablets† three times a day for two weeks. Dose was then reduced to two tablets at bed time and two during the day hours. Therapy was continued for from one to six months. Seventeen of the patients were on steroids at the time this new drug† was added to the regimen.

Most patients were seen at an interval of two weeks. Evaluation was based on patient satisfaction and on objective clinical findings.

TABLE 1.

RHEUMATOID ARTHRITIS

Structural Stage:

I. Osteoporosis
II. Slight destruction, swellings, but no deformities
III. Considerable destruction, deformities
IV. Ankylosis

Functional Class:

I. Complete function
II. Handicapped, but adequate
III. Very much limited
IV. Largely incapacitated

Improvement Grade:

I. Complete remission—Excellent
II. Minimal residual joint swelling—Good
III. Decreased symptoms—Satisfactory
IV. Unimproved—Poor

7. Bayles, T. B. and Tenckhoff, H.: Salicylate Therapy in Rheumatic Diseases. Scientific Exhibit, Amer. Acad. G. P., San Francisco (1959).

8. Hanzlik, P. J. and Presho, N. E.: Journal of Pharmacology, 26:61 (1925).

†The form we used was tradenamed Persistin® and is a product of Sherman Laboratories of Detroit. It is supplied in bottles of 90.

COMMENT

TABLE 2 presents the patient response and clinical results obtained with this therapy. Results were "excellent" to "good" in 33 and "satisfactory" in 10 of the 47 patients. One patient was not satisfied. Those who received "excellent" to "good" results included 27 of the 32 cases of the degenerative joint disease; both of the post-traumatic arthropathy and 4 of the 12 rheumatoid arthritis cases. The one case of bursitis, 7 of rheumatoid arthritis and 2 of degenerative joint disease showed "some" improvement in clinical signs and symptoms. These were classed as "satisfactory." In one case of rheumatoid arthritis no visible improvement in the symptoms was noticed and the patient complained of gastric intolerance to therapy. Three patients did not return after their first or second visit to the clinic. They obviously were not satisfied with the idea of changing to a salicylate therapy after being treated with steroids for long periods.

Seventeen of the patients were on steroids at the time the salicylate-acetylsalicylic treatment† was added to the regimen, but the amount of steroids was reduced at that time. Those who were able to reduce steroid dosage without sacrifice of pain control or decrease in joint function were classed as "excellent." Other factors considered in determining the improvement in grade are presented in Table 1. Most of the patients included in the study had a history of arthritic disease of several years.

Except for the one case mentioned above, complaints of gastric intolerance were generally absent. This striking difference from aspirin appeared to be responsible for better immediate acceptance of the therapy. However, its real value was in giving a constant relief through the night hours and consequently, reduction in morning pains and stiffness.

This study was very encouraging. Successful prolongation of the analgesic effect was made possible without gastric intolerance. The best patient satisfaction was observed in cases of degenerative joint disease (excellent to good 84 per cent). Clinical results are presented in Table 2.

TABLE 2.

CLINICAL RESULTS WITH PERSISTIN® THERAPY

Diagnosis of the Disease	Number of Patients	Response to Therapy: Excellent or Good	Satisfactory	Poor	Incomplete Follow-Up
Degenerative Joint disease	32	27	2	—	3
Rheumatoid Arthritis	12	4	7	1	—
Post-traumatic Arthropathy	2	2	—	—	—
Bursitis	1	—	1	—	—
Total	47	33	10	1	3

SUMMARY

1. There is now available an uncoated tablet containing 500 milligrams of salicysalicylic acid and 150 milligrams of acetylsalicylic acid.†

2. This was investigated for (a) its gastric tolerance, and (b) its ability to provide prolonged analgesia and relief of the morning pains. Our study included 47 patients with arthritic disease of varying stage. Both objective and subjective factors were considered in evaluating the efficacy of the drug.

3. Thirty-three of the 47 patients (70 per cent) received "excellent" to "good" relief of pain and an additional 21 per cent "satisfactory" relief. Gastric intolerance was absent, except in one case. The analgesic effect provided was of longer duration and patients successfully treated, experienced minimal morning pains.

The authors wish to express their appreciation to Drs. C. Castelli and Z. Shagaldian, medical residents for assistance in preparation of the data.

345 Hamilton Place

R. W. Ward, M.D.

South Orange

Antimalarials in the Treatment of Dermatomyositis*

While one case does not constitute a series, it is interesting that antimalarial drugs did seem to help this case of dermatomyositis; and that the clinical course fluctuated with the drug dosage. In view of the high mortality from dermatomyositis, the result is encouraging.

Dermatomyositis is the rarest of the collagen diseases. Although it is a distinct entity, it has many similarities to disseminated lupus erythematosus and scleroderma. The disease is characterized by a diffuse non-suppurative myositis of striated muscles. Cutaneous lesions, edema and prostration commonly accompany the myositis. Creatinuria is usually present in the acute phases of the disease. The morbidity and mortality are particularly high in children and adolescents.

The availability of corticosteroids constitutes a major advance in the treatment of dermatomyositis and the other collagen diseases. Because of their nonspecific, anti-inflammatory action, these drugs often suppress the acute manifestations of dermatomyositis and probably prolong life and prevent muscle fibrosis and contractures.

Antimalarial agents have been reported to be beneficial in rheumatoid arthritis,[1] chronic discoid lupus,[2] and disseminated lupus erythematosus.[3] Quinacrine is an acridine derivative capable of inhibiting cholinesterase and depressing the oxygen consumption of liver, brain and kidney slices. In concentrations of 10 milligrams per 100 cubic centimeters, it will inhibit lupus erythematosus cell formation *in vitro* in weak lupus erythematosus serums.[4] In a concentration of 40 milligrams per 100 cubic centimeters, it will inhibit the lupus erythematosus phenomenon in very potent lupus erythematosus serums. Animals treated with quinacrine have considerably increased secretion of 17-ketosteroids and markedly heavier adrenals.[5] There was histologic evidence that the drug stimulated the adrenal cortex with an increased production and mobilization of cortisone. This effect may partly explain the anti-inflammatory action of quinacrine.

Chloroquine is a 4-aminoquinoline, containing the same alkyl side chain as quinacrine. It is capable of interacting with nucleic acids and nucleoproteins. In disseminated lupus erythematosus, chloroquine has a marked antiphlogistic effect on artificially produced cutaneous inflammation and shortens the reparative phase of healing of artificially caused skin ulcers.[6]

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*This work is from the Department of Medicine, Hospital Center at Orange, N. J.

1. Cohen, A. S. and Calkins, E.: Ninth International Congress on Rheumatic Diseases, Toronto, 1957.

2. Rogers, J. and Finn, O. A.: A.M.A. Archives of Dermatology, 74:387 (1956).

3. Dubois, E. L.: Annals of Internal Medicine, 45:163 (1956).

4. Dubois, E. L.: A.M.A. Archives of Dermatology, 71:570 (1955).

5. Nagy, E. *et al.*: Dermatologica, 115:143 (1957).

6. Blaich, W. and Gerlach, U.: Hautarzt, 6:267 (1955).

A 49-year old white woman was first seen in November 1956. She had been in good health until March 1956 when she noted malaise, pain in both eyes and sudden decrease in visual acuity. An ophthalmologist could find no ocular pathology but glasses were prescribed. Generalized brownish pigmentation of the skin developed during the next four months. In June 1956 a non-pruritic, erythematous eruption appeared on the dorsum of the hands. Progressive weakness of the back and extremities and migratory muscle pain developed during the next month. She complained of difficulty in swallowing solid foods, although soft foods and liquids were well tolerated. X-rays of esophagus were interpreted as normal.

In August 1956 the illness suddenly increased in severity with profound weakness of the extremities, exertional dypsnea, diffuse muscle pain and a constricting sensation in the chest on exertion. A violaceous eruption developed on the forehead, upper eyelids, malar arches and chin. A sense of constriction was present in the abdomen, unassociated with gastro-intestinal or genito-urinary symptoms. During this month, she had three episodes of slurring of speech, each lasting about two hours, and accompanied by severe diarrhea. The stools were not dark, nor did they contain gross blood. The patient was admitted to another hospital in early September 1956. Shortly after admission massive edema of the face, neck and upper arms appeared for the first time. The only positive laboratory finding was an elevated sedimentation rate. Although repeated lupus preparations were negative, a tentative diagnosis of disseminated lupus erythematosus was made and the patient was discharged on 25 milligrams of prednisolone a day with gradual improvement. After several weeks the amount of prednisolone was gradually reduced, resulting in a prompt exacerbation of the illness with marked weakness and intensification of the eruption. Ulcerations appeared on the helix of the right ear, behind the left ear and on the dorsum of both hands. Only slight improvement in the muscle weakness resulted when the prednisolone was increased to 25 milligrams a day. In October 1956, soreness of the tongue, gums and nostrils was noted.

There had been a weight loss of fifteen pounds during the illness. There were no articular or periarticular symptoms nor was there a history of antecedent infection, drug ingestion, undue exposure to sunlight, or allergies.

Physical examination revealed a chronically ill, poorly nourished patient with normal vital signs except for a respiratory rate of 28. A violaceous, telangiectatic eruption was present on the forehead, upper eyelids, malar arches, nose, ears, tip of chin, and dorsum of the hands and fingers. It extended behind the ears and involved the V area of the anterior chest. While the involved skin was thin and atrophic, with areas of depigmentation and brownish pigmentation, edema was noted only in the eyelids. Present about the ears and on the dorsum of the hands were several superficial ulcerations, varying in size from 5 to 10 millimeters in diameter, covered by an adherent crust, and surrounded by a slight inflammatory reaction. Similar ulcerations were present on the buccal mucosa, gingiva and lateral surfaces of the tongue. The remainder of the skin was slightly hyperpigmented. Generalized muscle weakness and atrophy were evident, most marked in the shoulders, hands and pelvic girdle. The patient could not raise her hands above her head, nor could she achieve an erect position after squatting. In spite of the profound weakness and atrophy, the consistency of the muscles was normal and tenderness, tremors, rigidity and fasciculations were absent. Examination of the heart, lungs, abdomen, central nervous system and rectum was normal.

Prednisolone (25 milligrams a day) was continued. Quinacrine, 100 milligrams a day, was prescribed. Ten days later, she said she was stronger, less dyspneic and able to eat solid foods. The violaceous eruption had faded somewhat.

Although slow improvement continued, the patient was still disabled by her disease. In December 1956 she was admitted to The Hospital Center at Orange. Physical examination was essentially unchanged except that the mucosal and cutaneous ulcerations had healed. Slight increase in both muscle mass and strength was apparent. The cutaneous discoloration typical of quinacrine ingestion was present. Blood count, urinalysis, fasting blood sugar, blood urea nitrogen, total serum bilirubin, and basal metabolic rate were normal. The sedimentation rate was 31 millimeters per hour (Westergren). Three lupus preparations were negative. The 24-hour urinary creatine excretion was 118 milligrams (normal 0 to 200 milligrams). The electrocardiogram showed low voltage in the standard leads. X-ray examination of the chest was normal. During the gastro-intestinal series, she had considerable difficulty in initiating deglutition. Once this was overcome there was no evidence of obstruction, narrowing or functional deviation of the esophagus. The cricopharyngeus muscle was prominent, but did not impede passage of the barium. The remainder of this examination was normal. X-rays showed bilateral frontal and maxillary sinusitis. Biopsy of the skin showed thinning of the epidermis and a marked increase in the collagenous tissue of the underlying corium. The corium was thickened but very few cells were present. Sections from the muscle biopsy showed cellular infiltrates consisting of lymphocytes, histiocytes, fibroblasts and occasional plasma cells with small amounts of fibrinoid and fibrous tissue. There were areas of coagulation and liquefaction of muscle bundles, but no basophilic degeneration was identified. There were small areas of mononuclear cells in the interstitial tissue.

The quinacrine was discontinued because the patient objected to the skin discoloration. After a hospitalization of ten days, she was discharged on prednisolone, 45 milligrams a day, sublingual tablets of methyltestosterone, diethylstilbestrol, antacids and salt restriction.

There was questionable improvement during the next three weeks. Early in January 1957 she developed pitting edema of the legs and symmetrical crusted ulcers on the buttocks. An acute right lower lobe pneumonia necessitated readmission. Physical examination was essentially unchanged except for a 4 centimeter crusted ulcer on each buttock and moderate pitting edema of

the ankles and legs. The liver was palpable 3 centimeters below the costal margin. The heart was normal; venous distention was absent. The pneumonia responded rapidly to intramuscular penicillin, while the edema subsided with bed rest, salt restriction and diuretics. She was discharged on prednisone, 25 milligrams a day, methyltestosterone, diethylstilbestrol, oral diuretics and chloroquine, 500 milligrams a day.

During the next two months, the dysphagia disappeared and erythema and ulcerations cleared completely. Her strength improved sufficiently to allow resumption of full activity. In this period, the salt free diet, methyltestosterone, diethylstilbestrol and diuretics were discontinued. The prednisone was gradually decreased to 5 milligrams a day. The appearance of diplopia in late March 1957 made it necessary to stop the chloroquine.

In July 1957 the disease suddenly relapsed with dyspnea, weakness, edema of the eyelids, ulcers about the nails of several fingers and erythema of the face, hands and wrists. The tongue was painful but no lesions were visible. The prednisone was increased to 30 milligrams a day and the symptoms began to recede in the next two weeks. The prednisone was then gradually decreased to 10 milligrams a day. An extensive, erythematous, pruritic eruption was present in late August, in spite of continued improvement in the dyspnea and weakness. The rash involved the dorsum of the hands, forearms, axillae and both pectoral areas. She had small painful ulcers in the left axilla and at the base of the right third fingernail. Prednisone was increased to 25 milligrams a day with gradual clearing of the eruption. Each time an attempt was made to lower the dose of prednisone the rash increased in severity, even though there was no other clinical evidence of recurrence. In November 1957 hydroxychloroquine, 200 milligrams a day, was started and the prednisone quickly reduced to 10 milligrams a day. Although there was little change in the appearance of the rash, the ulcers healed promptly and the rash did not become worse as it had on previous attempts to reduce the dose of the steroid.

In January 1958, blood count, urinalysis, fasting blood sugar, blood urea nitrogen, albumin:globulin ratio, serum sodium and potassium, barium enema and chest x-ray were normal. The sedimentation rate was 35 millimeters (Westergren), the serum glutamic oxaloacetic transaminase 85 units (normal 5 to 40 units).

In May 1958, she was asymptomatic. No ulcers were present and the rash had completely subsided. When the disease remained quiescent, the prednisone and hydroxychloroquine were decreased to low levels and finally stopped.

After five months of complete remission, the disease relapsed with the sudden onset of pain in the right shoulder and ulcers on the lower back. She developed a small ulcer over each sacroiliac joint surrounded by a small zone of erythema. Around the bases of the fingernails there were multiple, pinhead-sized aneurysms, similar in appearance to the capillary microaneurysms seen in diabetic fundi. The palmar surfaces of the fingers showed numerous small telangiectatic areas which blanched on pressure and filled from the center. The upper eyelids were violaceous. Although some atrophy of the intrinsic muscles of the hand still existed, there had been an amazing recovery in strength and muscle mass in all other areas. The right shoulder was normal and there were no contractures. Prednisone was begun in doses of 10 milligrams a day and the ulcers healed within six weeks. The prednisone was then gradually decreased to 2.5 milligrams a day.

The patient was last seen in October 1959. An ulceration of the helix of each ear had appeared and disappeared without change in the prednisone dosage. There were no active skin lesions. An area of sclerosis and pitting of the skin was present distally on one finger.

The presenting complaints in dermatomyositis are related to the involvement of the skin and voluntary muscles. Weakness is always present and is usually accompanied by muscle pain, stiffness and tenderness. The involvement is symmetrical and bilateral, with the development of atrophy, fibrosis and contractures as the disease progresses. Fasciculations, tremors and rigidity are absent. The muscles of the neck, hands, shoulders and pelvic girdle are most often affected, although weakness of pharyngeal,[7] cardiac, intercostal[8] and extraocular muscles[9] may also cause symptoms. The muscles may be normal or swollen and "doughy" on palpation.

Cutaneous eruptions are almost invariably present at some time during the disease. The rash most frequently described is erythematous or violaceous, macular, mottled and telangiectatic. However, it may be pruritic, erysipeloid, ulcerative, bullous, exfoliative or psoriatic, and there may also be hypertrichosis, hyperhidrosis, pigmentation, urticaria, photosensitivity, atrophy and depigmentation[9]. The skin of the face, eyelids, forearms, wrists and hands is most often affected. There may be stomatitis, gingivitis, glossitis and oral ulceration. Calcifications in or under the skin, Raynaud's phenomenon and scleroderma-like changes[10] develop in occasional cases.

Edema is a prominent feature of dermatomyositis in about 80 per cent of cases. It

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8. Wainger, C. K. and Lever, W. F.: Archives of Dermatology and Syphilology, 59:196 (1949).

9. Domzalski, C. A. and Morgan, V. C.: American Journal of Medicine, 19:370 (1955).

10. Christianson, H. B. *et al.*: A.M.A. Archives of Dermatology, 74:581 (1956).

frequently, but not invariably, involves the areas affected by the rash. Serous effusions are uncommon. Occasional cases have clinical and pathologic evidence of rheumatoid arthritis,[11] while iritis, generalized lymphadenopathy, and splenomegaly are rare.[9] Pulmonary infiltrates have been reported.[12,13,14]

THERE are no pathognomonic chemical or histologic changes in dermatomyositis. The chief value of such studies is to exclude alternate diagnoses. Since the cutaneous and muscular components of dermatomyositis often wax and wane independently, the serum glutamic oxaloacetic transaminase provides a useful laboratory procedure for determining the activity of the myositis.[15]

Creatinuria is usually present in the acute stages of the disease. Creatine, a normal constituent of muscle is formed from glycine, arginine and methionine. It is present in the urine of prepuberal children (up to 4.2 milligrams per kilogram per day), during pregnancy and the puerperium, and occasionally in normal nonpregnant women. It is not found in the normal adult male on an adequate diet. Excessive creatinuria, denoting marked endogenous protein catabolism, may occur in Addison's disease, thyrotoxicosis, trichinosis, disseminated lupus erythematosus, starvation and myopathies other than dermatomyositis. However, it is found most frequently and in the largest amounts in the acute stages of dermatomyositis. Jager and Grossman [16] report a decreased creatine content of affected muscles.

Skin and muscle biopsy are important aids in the diagnosis of dermatomyositis. Thinning of the layers of the skin, vacuolation of the epidermis, and perivascular infiltrations of lymphocytes in the corium are the changes most frequently described. The muscles show degenerative changes, including vacuolation of the cytoplasm, loss of striations, altered affinity for stains, fragmentation and rupture of fibers, and an increase in the number of sarcolemmal nuclei. The interstitial tissue shows edema, small hemorrhages, and cellular accumulations of lymphocytes and plasma cells. The paucity of vascular involvement aids in differentiating dermatomyositis from other members of the collagen group.[16]

In adults the mortality rate in dermatomyositis is about 50 per cent. Most of the adults who survive for longer than one year recover with few, if any, sequelae. The disease is more severe in younger patients. In a recent study [17] of cases seventeen years of age or younger, it was predicted that 20 per cent of affected children would die within one year, 30 to 40 per cent would die within the next three to four years because of intercurrent infection, and of those who survive, only 20 per cent would return to full activity with no or minimal residual evidence of dermatomyositis. The remainder would have varying degrees of crippling because of dermal induration, muscle fibrosis and contractures.

The association of dermatomyositis and malignant disease is a much discussed question. In a recent review,[18] a 15 per cent incidence has been reported with equal distribution between males and females. Dermatomyositis usually preceded the malignancy, but there were several instances where the tumor preceded the dermatomyositis by an interval of from several weeks to seven years. The most common sites of malignancy in decreasing order of frequency were the stomach, breast, lung, ovary, lymphoma and leukemia. Although there were several other types of tumors, no carcinomas of the prostate or pancreas were found. Other writers [10] state that the association of these two diseases is coincidental, pointing out that clinical data suggest the association of scleroderma and malignancy. Dermatomyositis may improve when the tumor responds to therapy and relapse

11. Anderson, T. E.: British Journal of Dermatology, 64:71 (1952).
12. Marcus, I. H. and Weinstein, J.: Annals of Internal Medicine, 9:406 (1935).
13. Minnesota Dermatologic Society Meeting, Reported in Archives of Dermatology and Syphilology, 68:101 (1953).
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15. de Moragas, J. M., Perry, H. O. and Fleisher, G. A.: Journal of the American Medical Association, 165:1936 (Dec. 14, 1957).
16. Jager, B. U. and Grossman, L. A.: Archives of Internal Medicine, 73:271 (1944).
17. Everett, M. A. and Curtis, A. C.: A.M.A. Archives of Internal Medicine, 100:70 (1957).
18. Wiliams, R. C., Jr.: Annals of Internal Medicine, 50:1174 (1959).

with its recurrence. However, Talbott [19] states that careful study of reported cases does not substantiate the impression that improvement in the clinical manifestations of dermatomyositis will consistently follow suppression or cure of the malignancy.

In view of the reported effectiveness of antimalarial agents in closely related disease states, these drugs were utilized in this case. The myositis improved slowly and steadily without any relation to the course of the cutaneous lesions and without dramatic response to any form of therapy. The cutaneous manifestations relapsed repeatedly irrespective of steroid dosage. It was hoped that the antimalarials would result in improvement of the dermatitis without resorting to large doses of prednisone. The initial response to quinacrine was gratifying with some increase in strength, diminution in the acuteness of the rash and disappearance of the mucosal ulcerations. When the drug was stopped, there was a prompt recurrence of the eruption with cutaneous ulcers and edema. In January 1957 the addition of chloroquine was of definite value in controlling the eruption. This response occurred after an abrupt decrease in steroid dosage. From August to November 1957 the rash recurred each time an attempt was made to reduce the prednisone to lower levels. When hydroxychloroquine was added, the steroid dosage was quickly reduced without cutaneous relapse.

It is difficult to draw conclusions about response to therapy when only one case has been studied. This is particularly true in a disease such as dermatomyositis where spontaneous remission and relapse are characteristic. However, in the present case the cutaneous manifestations of dermatomyositis repeatedly subsided when antimalarials were used. Because of similarities to disseminated lupus erythematosus and other collagen diseases, one might expect such a response. These agents warrant further study in the therapy of dermatomyositis.

SUMMARY

A CASE of dermatomyositis is discussed with particular reference to the clinical manifestations and response to antimalarial agents. These drugs may prove to be an important adjunct in the treatment of dermatomyositis, particularly in the control of cutaneous manifestations.

19. Talbott, J. H.: Archives of Internal Medicine, 100:535 (1957).

120 Prospect Street

Hypnotizing the Alcoholic

Hypnotism may be useful in the treatment of chronic alcoholism. So says Dr. Michael M. Miller in an article in the November 14 (1959) Journal of the American Medical Association. The therapist aims to create an aversion to alcohol under hypnosis. Miller writes that in successfully treated cases, even the slightest whiff of alcohol causes an aversion reaction. Miller has treated 24 patients by this technic, some of whom have been alcoholic for as long as 34 years. He finds that usually two or three hypnotic experiences are sufficient. Of his 24 patients, three have relapsed, three are remaining abstemious but are taking no further treatment, and 18 are taking psychotherapy.

He usually has the patient test himself out after the first hypnotherapy and discovered that most patients develop vomiting when they try to drink after the first treatment.

One danger is that some of these patients become addicted to tranquilizers as a substitute for the alcohol and this has to be avoided.

MILTON E. LANDMAN, M.D.

Bloomfield

Clinical Trial of a New Antidepressive Agent

Dr. Landman has tried a new energizing combination and found that 46 per cent of patients suffering from depression were helped by it. While this is not a spectacular improvement rate, some of the results were so dramatic as to warrant serious consideration of this benactyzine-meprobamate combination.

UNTIL recently electroshock has been the only really effective rapid treatment of the severely depressed patient. Older cerebral stimulants such as the amphetamines and caffeine were of limited value. Recently a number of new more effective agents have been introduced. One such combination is made up of 400 milligrams of meprobamate and 1 milligram of benactyzine hydrochloride.*

Alexander [1] found this effective in the treatment of certain depressed patients. He stated [2] that he could select appropriate patients through the use of the electroencephalogram and the psychogalvanic reflex.

In the present study, I have tried to appraise the efficacy of this combination in office patients and to determine if there is any type of patient in whom it is particularly indicated.

*Marketed by Wallace Laboratories under their trademark of Deprol®.

1. Alexander, Leo: Journal of the American Medical Association, 169:166 (1958).

2. Alexander, Leo: Paper read May 10, 1958, before the annual meeting of the Society of Biological Psychiatry.

METHOD

FIFTY patients were chosen from an internal medicine practice. The group included 22 males and 28 females whose ages ranged from 16 to 70 with an average of 49 years. Each patient showed symptoms of depression. Among these were sadness, insomnia, loss of interest in normal activities, withdrawal, irrational concern with problems, loss of pride in personal appearance and hypochondriasis. Almost all showed anxiety manifested by "jitteriness," diffuse concern and restlessness. Depression was the prime indication for use of the drugs and whether this or anxiety predominated was not considered.

Initial dosage was usually one tablet four times daily except in small persons where a half a tablet was given. The dose was adjusted thereafter to the clinical results. Marked drowsiness often occurred initially which usually disappeared after a few days. This was often desirable in initially controlling symptomatology.

Responses were individually evaluated as

excellent, good, fair or poor according to the following criteria:

Excellent: A patient whose personality returned to its previous state.

Good: A patient who, while not completely returned to his normal state, managed to carry on a reasonably well adjusted life.

Fair: A patient who, while showing some improvement, still fell far short of returning to his normal state.

Poor: A patient who showed no improvement or had to discontinue therapy because of side-effects.

RESULTS

RESPONSES ranging from "good" to "excellent" were noted in 23—that is, in 46 per cent of the patients while the remaining 27 (or 54 per cent) were in the "fair" to "poor" group and classified as failures. Among the failures were six who had to discontinue the drug because of severe and persistent drowsiness and three who had to be referred for electroshock therapy. Among those patients who showed an excellent response were two who had previously received electroshock without benefit.

Most of the patients were not helped significantly (54 per cent against 46 per cent—see Table 1). Still, many dramatic clinical remissions were achieved. Best results were in patients with primary depression regardless of severity, attended by a minimum of anxiety. Nine of the 13 "excellent" responses were primarily depressions. Of the 18 complete failures 11 were in cases where anxiety predominated over depression (see Table 2). When the therapy was effective it allowed the patients to discuss their problems in a much freer fashion and the impression was gained that these drugs might prove helpful in the hands of definitive psychotherapists.

TABLE 1.

EFFECTIVENESS OF THE BENACTYZINE-MEPROBAMATE COMBINATION

Result	No. of Patients	Per Cent of Group
Excellent	13	26
Good	10	20
Fair	9	18
Poor	18	36
Totals	50	100
Excellent or Good	23	46%

TABLE 2.

RESPONSES OF 50 PATIENTS TO BENACTYZINE-MEPROBAMATE CLASSIFIED ACCORDING TO PREDOMINANT SYMPTOM

($p = 0.5$)

	Responses				
Symptom	Excellent	Good	Fair	Poor	Total
Anxiety	4(17%)	4(17%)	5(20%)	11(46%)	24
Depression	9(35%)	6(22%)	4(16%)	7(27%)	26
Totals	13(26%)	10(20%)	9(18%)	18(36%)	50

Excellent or good:
34 per cent of patients with primary anxiety.
Excellent or good:
57 per cent of patients with primary depression.

SUMMARY

A SERIES of 50 patients with depressive states were treated with a combination of meprobamate and benactyzine hydrochloride.* This was found to be a worthwhile therapy in many ambulant patients and often averted electroshock or institutionalization.

Case 1: A known depressive psychotic had previously been treated with shock and prefrontal lobotomy. After having been well for two years, she came to the office with marked weight loss, anorexia, complete withdrawal, disinterest in her personal appearance, insomnia, sadness, and loss of interest in life. She showed little evidence of agitation or anxiety. The initial dose of four tablets* a day was continued for two weeks; for the next month the dose was reduced to two tablets a day. The dose was finally reduced to one tablet and the patient is now completely normal.

Case 2: A 59-year old woman was generally a rather hypochondriacal and "worrisome" individual. She came to my office in April 1959 with severe depression and suicidal feelings. After taking four tablets* for two months, she gradually made an excellent and almost complete recovery. The dose was reduced to two tablets daily, and then to one which is her present regime. There has been no return of her depressive symptoms. She experienced mild drowsiness under the medication, but this was relieved by giving supplemental Ritalin.®

Case 3: A 62-year old man was a known depressive psychotic. He had been treated previously with electric shock and psychotherapy. His symptoms included insomnia, sadness, self-reproach, and loss of interest in life. His respone to four tablets* daily was good at first. However, this soon began to fade. After a month, the dose was increased to eight tablets daily. He experienced an exacerbation of his symptoms, and complained of staggering and dizziness. Since the treatment was considered a failure, he was institutionalized.

Of particular interest was another case in which the patient's condition was not typical of the other members of the group.

Case 4: A 37-year old man was brought to the office greatly disturbed by hallucinations, violent fears, trembling, and crying spells. Because he was completely unmanageable at home he was referred to a psychiatric hospital. After a week he was removed against the advice of the hospital authorities and brought to my office. A trial of meprobamate and benactyzine* was attempted more or less in desperation. Initial dose of 4 tablets daily was later increased to 6 and then to 8. Lessening of the symptoms including hallucinations occurred over a six-week period until the patient was finally able to carry out a simple occupation and maintain a fairly normal home life. For the last 15 months he has maintained his remission on four to six tablets daily.

1185 Broad Street

Cervical Rib

Patients with cervical rib have pain in the forearm on exercise, which is relieved by resting. The pain is produced more quickly if the limb is used in an elevated position. Paresthesia and numbness of the fingertips are noted. Shallow ulcers by the side of the nails or over the finger are common.

Examination reveals coldness and discoloration of the hand and forearm and loss of the peripheral pulses. The color of the hand varies with posture—pale when elevated and reddish when dependent. No sensory loss corresponding to the distribution of the peripheral nerve roots is detected.

These are signs and symptoms indicating occlusion of the main arteries of the limb; and the sudden onset points to embolism as the cause of the arterial obstruction.

Explanation of the phenomena depends on whether the rib is complete or incomplete. If the rib is complete, vascular complications ensue because of compression of the subclavian artery. This compression leads to peripheral dilation of the artery because of the distribution of eddy currents. The artery is then readily thrombosed and detachment of small emboli will produce occlusions of arterial segments distal to the subclavian artery.

Arteriograms are presented* indicating occlusion of vascular arterial segments distal to the subclavian artery. These embolic occlusions account for the sudden onset of symptoms and for local areas of ulceration.

When the cervical rib is complete there are no neurologic complications, since there is no compression of the brachial plexus. However, when the cervical rib is incomplete, a fibrous band attaches the end of the rib to the first thoracic rib. This fibrous band compresses the nearby brachial plexus with the well-known clinical picture of segmental sensory loss and wasting of the small muscles of the hand. The radial side of the hand appears to be the one more frequently involved.

*Ross, James P.: Annals of Surgery, 150:340 (1959).

Chondrosarcoma Study Project

The National Cancer Institute is now studying chondrosarcoma to determine the effects of radioactive sulfur-35. If you have any such patients, telephone Dr. J. R. Andrews at extension 3351 at Oliver 6-4000. This is a Washington, D. C. number. Or write to Clinical Director, National Cancer Institute, Bethesda 14, Md.

Board of Trustees: March 20, 1960

Following is an abstract of some of the activities of our Board of Trustees at its session in Trenton, March 20, 1960.

The Board received an amended resolution from the New Jersey Boards of Nursing, the text of which follows:

The New Jersey Board of Nursing, having studied the question of administration of intravenous therapy further, and after several conferences with the representatives of the State Board of Medical Examiners and representatives of the Hospital Association, have concluded that under certain circumstances the administration of intravenous therapy by registered nurses licensed by this board shall be permitted.

The New Jersey Board of Nursing has agreed that intravenous therapy may be administered at the direction of a licensed physician or surgeon of this State by registered nurses licensed in this State where they have received a course of instruction in intravenous therapy and have been approved by the medical staffs of the approved hospitals of this State.

Only the following medications may be administered by such registered nurses as heretofore referred to:

1. Glucose
2. Saline solution
3. Vitamins
4. Ringer's lactate solution
5. Amino acids
6. Antibiotics

The New Jersey Board of Nursing is agreed further that in order to prepare registered nurses for the administration of intravenous therapy in the permitted categories, a course in intravenous therapy shall be included in the basic curriculum of the approved schools of professional nursing of this State, and that such course shall be approved by the New Jersey Board of Nursing.

The New Jersey Board of Nursing is further agreed that under no circumstances shall practical nurses, nurses aides, orderlies, nurse technicians or any other limited category connected with the nursing profession be permitted to administer intravenous therapy.

It is further agreed that those registered nurses who have heretofore or may hereafter receive training prior to the establishment of an approved course in intravenous therapy in the basic curriculum of the approved schools of professional nursing of this State, be recognized as being qualified to continue to administer intravenous therapy in the permitted categories provided they receive the approval of the medical staffs of the approved hospitals of this State.

In response to a question by Dr. Sica concerning the inclusion of blood, Dr. Mulligan and Dr. Allman, speaking for the State Board of Medical Examiners, stated that blood and a few other things will be added; no difficulty in making additions is anticipated; and the Deputy Attorney General feels he can take care of the matter.

DRUGS FOR MENTAL PATIENTS

Dr. Edward J. Duffy, an officer of the State Mental Health Association, had asked our Committee on Mental Health to study the question of procuring necessary medication for patients discharged from, or on furlough from, mental hospitals. The Special Committee on Mental Health now asks whether The Medical Society of New Jersey desires a survey to ascertain how many patients would be involved. A second question concerns our Society's attitude towards a suggestion that N. J. Association for Mental Health might furnish or pay for tranquilizing drugs and other medication for medically indigent patients.

The Committee suggested that such a survey, if necessary, be carried out by some outside agency.

The special committee agreed that all patients who need medication of this nature should have it. Apparently there is a group of patients whose needs are not being met. The special committee approved of the underwriting of the cost of these drugs for patients by the New Jersey Association for Mental Health, when such drugs are prescribed by a physician and indigency is certified.

The report and recommendations of the special committee were approved.

NURSING CURRICULUM

At its meeting on February 23, our Medical-Hospital Liaison Committee considered the following resolutions adopted by representatives of hospital schools of nursing. This resulted

from a conference called to discuss changes in the curriculum for hospital schools of nursing proposed by the New Jersey State Board of Nursing.

1. That schools of nursing admissions requirements as set forth in the proposals of the State Board of Nursing are too restrictive and should be restudied with the aim of permitting individual schools to exercise discretion in admitting students who do not meet the proposed minimum admission standards set forth by the State Board of Nursing.

2. That the State Board of Nursing be asked to give further consideration to the addition of the two-year nurse training program of a required, one-year, salaried, internship to be served in an accredited hospital school of nursing.

3. That the State Board of Nursing's proposal that evening or night clinical rotation for student nurses be limited to 40 days for the three-year training program be amended to permit the number of evening and night hours to be left to the discretion of individual schools of nursing, with the provision that there be adequate supervision of students on evening and night hours.

4. That scheduling of class hours and their distribution over the three-year training program be left to the discretion of the individual schools of nursing.

5. That the word "may" in the sixth general principle in the Nursing and Allied Arts Area (page 9) be changed to "should" so that the provision would read, "Principles of leadership and management should be included and principles of disaster nursing should be integrated in the content of Nursing and Allied Arts."

6. That the State Board of Nursing be requested to make a statement of uniform policy on the subject of hospital schools of practical nursing, and that such schools be encouraged as a means of alleviating the nurse shortage.

The liaison committee concurred in and approved the above resolutions of the conference. The liaison committee recommends:

1. That these resolutions be incorporated in a joint statement of the Medical Society and Hospital Association for submission to the respective boards for approval.

2. That the boards be asked to designate representatives to present the statement, as approved, to the State Board of Nursing and to discuss it with that Board.

3. That, following the meeting with the Board of Nursing, copies of the statement be sent to the Attorney General of the State, the State League for Nursing and the State Board of Medical Examiners.

The Board concurred in the resolutions and recommendations of the liaison committee.

SPECIAL MEETING OF DELEGATES

The Board heard a report of the special meeting of our House of Delegates held on March 13, 1960. Purpose of this session was to discuss existing and proposed riders for diagnostic services under Blue Cross and Blue Shield contracts, and to obtain direction from the House of Delegates as to the position of The Medical Society of New Jersey concerning such riders.

Of the 425 accredited members of the House (1959 list) 314 registered and attended the meeting; that is, 74 per cent.

Dr. Allman moved—seconded by Dr. Kaufman, and *defeated* by a majority vote—that the House of Delegates approve a joint rider to be issued by Blue Cross and Blue Shield.

2. Dr. Donnelly moved—seconded by a number of delegates, and unanimously *carried*—that the President appoint a committee to meet with the Commissioner of Banking and Insurance to state our reasons against the contemplated Blue Cross rider which would permit diagnostic services on an out-patient basis in hospitals.

3. Amendment to Dr. Donnelly's motion—made by Dr. Robie, seconded, and carried: This committee should be empowered to sit down with Blue Shield, with Blue Cross. We don't want to tie their hands just to go and see the Banking Commissioner. That committee should do work in various spheres, those that they think are necessary to help iron this thing out.

DELEGATES: 1960

Of the 125 delegates who did *not* attend the majority of the 1959 sessions of the House of Delegates, 73 did *not* attend the special session on March 13, 1960. Article IV, Section 4 of the Constitution provides:

> A vacancy shall exist in the delegation of any component society whenever one of its delegates ceases to be in good standing, or neglects to attend a majority of the sessions of the House of Delegates at two consecutive meetings (annual or special). When such a vacancy occurs, the component society shall fill the unexpired term.

In determining the status of the 73 delegates who did not attend "a majority of the sessions of the House of Delegates at two consecutive meetings (annual or special)", an opinion from the Society's counsel was requested. Mr. Backes replied:

I have been asked an opinion concerning the meaning of the words "neglects to attend" found in Article IV, Section 4, paragraph (d), of the current Constitution of The Medical Society of

New Jersey. The similar portion of the old Constitution reads "fails to attend" where the amended Constitution currently reads "neglects to attend."

Winston's dictionary defines neglect as follows: "to fail to do, by carelessness or design."

The intention of the constitutional convention in recommending the word change referred to above was to lessen the impact of non-attendance, *i.e.*, to waive the creation of a vacancy in the case where failure to attend a majority of the sessions of the House at two consecutive meetings (annual or special) was not through carelessness or design of the delegate.

It is my opinion, therefore, that both the definition of the word neglect and the intention expressed at the time of the change made indicate that a vacancy is not created in a component society's delegation where there has been no carelessness or design in failing to attend on the part of any delegate.

Dr. Greifinger recommended:

1. That those delegates whose absence from the majority of the sessions of two consecutive meetings of the House of Delegates was in the view of the Secretary of this Society not due to carelessness or design, be regarded as acceptable accredited delegates for the next meeting of the House of Delegates;
2. That personal illness, death in the immediate family, religious objections, and other valid reasons be accepted by the Secretary;
3. That the burden of proof be placed on the individual delegate to justify his absence to the Secretary of this Society by completion and prompt return of a proper form; and
4. That component societies be notified as soon as practicable of the creation of vacancies in their delegation because of demonstrated "neglect to attend" upon the part of any of their delegates.

Upon motion by Dr. Bowers, the recommendations were approved.

MEDICARE

Two supplemental agreements to the Medicare Contract have been received for execution:

1. Amendment to Code 4822—modifies the provision re routine urinalyses in maternity cases.
2. Amendment to Joint Directive with reference to a change in the title of DD form 1251 from "Medicare Permit" to "Non-Availability Statement."

Dr. McCall recommended that the two supplemental agreements be accepted and that the proper officers be authorized to execute the papers. Upon motion, this was approved.

RETIREMENT PLAN FOR PHYSICIANS

The special committee has met several times to consider a retirement plan for physicians. A group policy offered by Prudential was considered. It is the opinion of the committee that the policy offers nothing which the individual physician cannot do or get for himself.

It is the recommendation of the special committee to the incoming President that the special committee be retained and be permitted to continue its study of the possibility of a retirement plan for physicians. This recommendation was approved.

ANNUAL MEETING SECTIONS

Two New Jersey specialty societies have publicized annual meeting section programs of The Medical Society as the "annual spring meeting of the New Jersey (specialty group) in conjunction with the (specialty) section of the State Medical Meeting." Both specialty societies have been notified that their announcements were in error. This assumption on the part of specialty societies is something new, and it is suggested that the Board of Trustees again inform the New Jersey specialty societies that, in accordance with the adopted rules and regulations for sections, "no specialty group in New Jersey is in any manner connected with The Medical Society of New Jersey except insofar as physicians may be members of both groups. The section programs at the annual meetings of The Medical Society of New Jersey are arranged by and for our members, and all publicity in connection with the annual meeting program is handled by the Council on Public Relations."

Dr. Allman moved—seconded by Dr. Greifinger, and carried—that the Chairman of the Committee on Annual Meeting in collaboration with the President notify the specialty societies of proper procedures and arrangements in connection with the annual meeting programs.

HEALTH CARE OF THE AGED

The Joint Council on Health Care of the Aged offered the following resolution:

1. That the purpose and function of the New Jersey Joint Council to Improve the Health Care of the Aged—as accepted by the members of the Joint Council at a meeting on February 21, 1960—be approved by the Board of Trustees.
2. That the Joint Council be authorized to establish a source material library on the subject of "aging" in the office of The Medical Society of New Jersey—with no costs involved.
3. That the Joint Council be supplied with information on legislation pertaining to the aged by legislative committees of the organizations represented on the Joint Council.
4. That the Joint Council sponsor a state-wide conference on "Health Care of the Aged in New Jersey."
5. That, if it is found necessary, the Joint Council be authorized to explore the possibility of conducting a survey through a fact-finding agency if the funds for such a survey can be obtained from a foundation.

Upon motion by Dr. Sharp—seconded by Dr. Schretzmann, and carried—the recommendations of the Joint Council were approved.

AMENDMENTS TO SOCIAL SECURITY ACT

A telegram from the A.M.A. reported that the House Ways and Means Committee would soon consider amendments to the social security act. The A.M.A. requested that telegrams be sent to Secretary Flemming and Vice-President Nixon.

Dr. Allman reported on a recent meeting of A.M.A. representatives with Secretary Flemming. There are four proposals for amending the social security act, three of which are no better than the Forand Bill. The fourth would provide for matching federal and state funds to buy voluntary insurance for those people over 65; the funds would come from general revenue rather than from social security taxation. The Secretary was told this fourth proposal was the only one which the A.M.A. would support.

Dr. Greifinger moved—seconded by Dr. Donnelly, and carried—that the President write Secretary Flemming and Vice-President Nixon stating that The Medical Society of New Jersey supports the point of view officially presented by A.M.A. representatives recently, that the Society is opposed to H.R. 4700 (Forand Bill) and all similar legislation; and call their attention to the Society's official opposition to H.R. 4700 as presented before the House Ways and Means Committee in July 1959.

EDUCATION EXHIBIT

Dr. Bowers moved—seconded by Dr. McCall, and carried—that the Society co-sponsor the exhibit at the meeting of the New Jersey Education Association but that the New Jersey Academy of Ophthalmology and Otolaryngology defray the cost of distributing the brochure by having it reproduced at Academy expense in whatever number is desired. The copies of the brochure on hand in the Society's offices are already earmarked for distribution.

ADVERTISEMENTS FOR CONTACT LENS FITTINGS

Dr. Mulligan exhibited the only two advertisements carried in THE JOURNAL (April 1959) concerning contact lens which were for firms offering service to physicians. Dr. Greifinger pointed out that advertisements could not "indicate the physicians to whom the patient is to be referred" as stated in the recommendation. On motion, the recommendation was disapproved.

MSP—PRESIDENT ON PLAN BOARD

At its meeting on February 23, 1960, the Plan Board adopted a resolution amending Article IV of the Plan Bylaws to increase the number of Trustees from 20 to 21, and to include as a Trustee "the President of The Medical Society who shall serve as a Trustee during his respective term in office."

The Plan Board approved the nomination of F. Clyde Bowers, M.D., as a member of the corporation and of the Board of Trustees of MSP to serve as a trustee during his term as President of the Medical Society, subject to the approval of the nomination by the Medical Society.

Upon motion by Dr. Schretzmann—seconded by Dr. Greifinger, and carried—Dr. Bowers' nomination was approved.

H. R. 7966

A communication from the Essex County Medical Society called attention to H. R. 7966 which would amend the definition of "medical

services" in Section 601(6), Title 38, U. S. Code, to include the services of optometrists. This would classify optometric services as "medical services" and provide federal compensation to optometrists for out-patient care given veterans with service-connected conditions. The Essex County Medical Society has gone on record as disapproving this legislation as being contrary to the interest of the veteran and the public, and requested that the State Society voice opposition to the bill and communicate its position to the proper members of Congress.

Dr. Blaisdell reported that the A.M.A. has taken the position of being opposed to such fringe type legislation, and recommended that the Society notify the New Jersey members of Congress that this is also the position of The Medical Society of New Jersey.

Dr. Allman moved—seconded by Dr. Bowers, and carried—that the Board concur in the position of the A.M.A. with reference to H. R. 7966 and that the President write the New Jersey representatives in Congress that the position of The Medical Society of New Jersey is in accord with the position of the A.M.A.

REGISTRATION OF PHYSIOTHERAPISTS

Received and noted was a communication from the State Board of Medical Examiners stating that it had officially taken action disapproving of A-177 which would provide for the registration and licensure of physical therapists and/or physio-therapists. It was noted that this position is consistent with the Society's position of disapproving A-177.

Council to Improve the Health Care of the Aged

The New Jersey Joint Council to Improve the Health Care of the Aged, as its name implies, is to assist the principal purveyors of health services in their efforts to improve health care of the aged, and to cooperate with the National Joint Council to Improve the Health Care of the Aged.

The New Jersey Joint Council is a mechanism for:

1. Exchange of information on activities and plans of its members and other organizations active in the field of aging;
2. Coordination of related programs conducted by member organizations;
3. Development, where indicated, of jointly sponsored projects; and
4. Dissemination of information on health care of the aged to the public, the professions, and interested agencies—both voluntary and governmental.

The Joint Council is composed of the New Jersey State Dental Society, the New Jersey Hospital Association, the New Jersey State Nurses' Association, the Licensed Nursing Homes Association of New Jersey, and The Medical Society of New Jersey. The Joint Council may include representation from other organizations whose major activity is directly concerned with health care.

Each member organization is to be represented by not more than four persons. On matters necessitating a vote, each member organization shall have one vote.

Meetings shall be held monthly, or at the call of the chairman.

Among the activities with which the Joint Council shall concern itself are the following:

1. Identifying and analyzing the health needs of the aged;
2. Appraising available health resources;
3. Fostering effective methods of payment for health care;
4. Aiding in the stimulation of development of community programs to improve the health care of the aged;
5. Fostering health education programs;
6. Informing the public of the facts related to health care of the aged; and
7. Dissemination of information regarding proposed legislation.

Examples of such activities include:

1. Active cooperation with the Governor's Commission on Aging.
2. Efforts to extend special types of hospital, surgical, medical, dental, nursing, and nursing home coverage for older persons by prepayment plans and health insurance as recommended by the member organizations.
3. Provision of leadership in efforts to stimulate adequate health care program at state and local levels for the aged.

4. Development of home care and special dental home care programs for the aged.

5. Exchange of information on administrative procedures and cost accounting.

6. Promotion of homemaker service programs.

7. Stimulation of rehabilitation of institutionalized and non-institutionalized persons.

8. Review of the activities of other organizations active in the field of aging.

9. Liaison with other organizations (see IV, B,8) and offering of advice on the health care aspects of their programs.

10. Leadership and cooperation with other organizations in improving health care services and facilities.

11. Inventory of medical and dental facilities and services available to the aged, such as nursing homes and homes for the aged.

12. Initiation or cooperation with other organizations in the development of local agencies and other devices designed to supply information on facilities and services available to the aged who are in need of health care.

13. Study and publicizing of the various mechanisms which aid in financing the health services required by the aged.

14. Periodic public reports.

The Council expects to sponsor a state-wide colloquium on care of the aged. This will probably be in the fall of 1960.

Council on Public Health

The following recommendations of the Special Committee on Conservation of Vision were approved by the Council on Public Health at its meeting in Trenton on Wednesday, March 16, 1960:

1. That the week of September 26—October 1 be designated Eye Health Week, that recognition of this by the Legislature and/or the Governor be sought, and that a program similar to the 1959 program be carried out; that Dr. Arthur Sherman be designated Program Director.

2. That The Medical Society of New Jersey and the New Jersey Academy of Ophthalmology co-sponsor an exhibit on eye and ear services in the schools, to be presented at the November, 1960 meeting of the New Jersey Education Association.

(Note: The NJOO presented such an exhibit in the past, and having secured an eye exhibit is seeking an ENT exhibit; the Academy will defray the expense of fees for the exhibit space and for housing the personnel, and reproduction of the brochure (see No. 3) for distribution. Approved as amended, by the Trustees on March 20)

3. That The Medical Society of New Jersey make available the Society's report "Referral of School Children for Eye Care" for distribution at the Education Association meeting to appropriate visitors at the booth. This was disapproved by the Trustees on March 20, 1960.

4. That advertisements soliciting the referral of patients for contact lens fittings *not* be accepted by THE JOURNAL of the Society unless the advertisement clearly indicates the physician to whom the patient is to be referred. This was disapproved on March 20 by the Board of Trustees.

5. That The Medical Society of New Jersey approve the discontinuance of licensure of optical mechanics (now defined in New Jersey Statutes as "ophthalmic technicians") and take steps to secure in conjunction with such change in the law such other changes as are necessary to exclude the application of any portion of this law not only to the physician, but to anyone employed by him or working under his direction. This was referred to Council on Legislation.

6. That the services of the Special Committee on Conservation of Vision and the good offices of the New Jersey Academy of Ophthalmology and Otolaryngology be utilized to acquaint the opticians with the position of the Medical Society and secure, if possible, their support of the necessary changes in the law, and if this is not possible, to accomplish this matter with the least possible friction. This was referred to Council on Legislation.

7. That The Medical Society of New Jersey protest vigorously to the New Jersey members of Congress the enactment of H.R. 7966 —to amend the definition of "medical services" to include services of optometrists. This was referred to Council on Legislation.

Supplementary List No. 4

to the

1959-60 Membership Directory

Memberships reported from April 11, 1960 through May 10, 1960

R—Reinstated
N—New

	Name	Address	County	Practice
		ACTIVE MEMBERS		
R	Abbott, Charles C.	Medical Center, Jersey City	Hudson	Teaching
R	Axilrod, Maurice H.	2620 Pacific Ave., Atlantic City	Atlantic	G-U, General
N	Barach, Richard L.	Princeton Hospital, Princeton	Mercer	Rad
R	Baron, Leo E.	26 Prospect Place, North Plainfield	Union	General
N	Bauer, William F.	49 High St., Newton	Sussex	Surg
N	Bauer, William F., Jr.	Woodland Rd., Brookside	Morris	....
R	Bevinetto, Jack R.	1 S. Stanley Rd., South Orange	Essex	General
N	Bonner, William T.	Gold & Washington Sts., Toms River	Ocean	....
R	Borino, John W.	24 Fulton St., Newark	Essex	Ind Med, Traum Surg
N	Bruce, Edwin T., Jr.	28 E. 38th St., Brant Beach	Ocean	General
N	Cohen, Reuben J.	109 W. Main St., Mays Landing	Atlantic	General
N	Crosett, Alexander D., Jr.	Overlook Hospital, Summit	Union	....
N	DeBari, Mario J.	305 Park Ave., Hoboken	Hudson	....
N	Dooley, John T.	251 E. Broadway, Salem	Salem	....
N	Feder, Larry L.	82 Danforth Ave., Jersey City	Hudson	Int Med
N	Friscia, Pascal	Somerset Hospital, Somerville	Somerset	....
R	Howell, Thomas W.	837 Tact. Hosp., Shaw AFB, South Carolina	Essex	USAF
R	Hulizman, Ellis	602 Beacon St., Moorestown	Camden	....
N	Katcher, Avrum L.	Hunterdon Medical Center, Flemington	Hunterdon	....
N	Keeler, Keith C.	Mountainside Hosp., Montclair	Essex	Phys Med, Rehab
N	Lello, Mark	853 S. 12th St., Newark	Essex	..
N	Leibow, Sheldon G.	535 New Brunswick Ave., Perth Amboy	Middlesex	Ped
N	Levinson, Sol	Patterson Army Hosp., Fort Monmouth	Monmouth	Int Med
R	Lotman, Harry A.	1067 Springfield Ave., Irvington	Essex	Surg
R	Manno, Bruno V.	134 Heller Parkway, Newark	Essex	General
N	Martin, Christopher M.	Seton Hall College of Med., Jersey City	Hudson	....
R	Rizzoli, Luigi	15 Peck Ave., Newark	Essex	....
N	Rizzolo, Peter J.	Flemington	Hunterdon	....
N	Salmon, Louis R.	Apple Farm Rd. & Hwy 35, Middletown	Monmouth	Oph
N	Wirdyka, Dorothy A.	Flemington	Hunterdon	..

Abel, David H.	311 Grove St., Montclair	Essex	Child Psy
Abel, Frances R.	311 Grove St., Montclair	Essex	Int Med
Angulo, Armand J.	346 Richey Ave., West Collingswood	Camden	Resident
Baldi, Aldo G.	Monmouth Medical Center, Long Branch	Monmouth	Path
Beran, Irving N.	12 N. 27th St., Camden	Camden	General
Cane, Carlos M.	252 Dayton Ave., Clifton	Passaic	Urol
Cane, Nayade G.	252 Dayton Ave., Clifton	Passaic	Ob, Gyn
Carnes, Harry M.	346 Richey Ave., West Collingswood	Camden	General
Casazza, John A.	286 Broad St., Red Bank	Monmouth	General
Coant, Jacqueline G.	504 White Horse Pike, Collingswood	Camden	Ped
Colfax, Jane A.	83 Bartholf Ave., Pompton Lakes	Passaic	Ob, Gyn
Darrow, Gerald D.	135 Cornelia St., Boonton	Morris	General
Del Giudice, Vincent J.	179 Lee Ave., Haledon	Passaic	....
DeRobbio, Francesco	Leonardville Rd., Leonardo	Monmouth	General
Freundlich, Melvin H.	659 Kearny Ave., Kearny	Essex	....
Irmiere, Victor J.	844 Valley Rd., Wayne	Passaic	General
Jurkans, Anton	Box 156, Greystone Park	Morris	....
Kaplan, Charles	20 Brookside Ave., Somerville	Somerset	Resident
Keeley, Francis X.	311 N. Woodstock Dr., Haddonfield	Camden	Int Med
Lebeau, John J.	346 Richey Ave., West Collingswood	Camden	General
Marchese, Nicholas A.	413-22nd St., Union City	Hudson	General
Myndiuk, Jaroslaw	34 Coit St., Irvington	Essex	....
Nichols, Warren W.	Municipal Hosp., Camden	Camden	....
Pagliaro, Dominic A.	57 Pitney Ave., Spring Lake	Monmouth	Orth Surg
Portenar, Myron A.	419 First St., Lakewood	Ocean	Oph
Riccioli, N. Frank	383 Lakeview Ave., Clifton	Passaic	General
Rodgers, Robert A., Jr.	204 High St., Mount Holly	Burlington	Ob, Gyn
Ross, Carl S.	169 Harrison Ave., Montclair	Essex	....
Rubin, Robert J.	905 Watchung Ave., Plainfield	Union	Gen Surg
Rushton, Harold W.	577 Stevens St., Camden	Camden	Neur-Surg
Schapiro, Bernard L.	Hunterdon Med Center, Flemington	Hunterdon	Resident
Schulmann, Marcel J.	1486 Haddon Ave., Camden	Camden	Orth Surg
Schwarz, Gerta	83 Highwood Terr., Weehawken	Hudson	Psy
Schwarzschild, Walter	200 Kings Hwy., Erlton	Camden	....
Seltzer, Jacob	525 New Brunswick Ave., Perth Amboy	Middlesex	Orth Surg
Shegedyn, Taras	80 Clinton Ave., Newark	Essex	....
Shinbein, Aaron	2450 Juniper Dr., Augusta, Ga.	Essex	....
Siegler, Marvin M.	2247 Lemoine Ave., Fort Lee	Bergen	....
Skelton, Jay B.	333 Park St., Montclair	Essex	....
Smith, Arthur M. J.	374 Livingston Ave., New Brunswick	Middlesex	Int Med
Smulkstys, Albinas	223 Bridgeboro St., Riverside	Burlington	General
Snope, Frank C.	13 Seventh St., Frenchtown	Hunterdon	Resident
Spiro, Alfred J.	U.S.P.H.S., Staten Island, N. Y.	Essex	Ped
Sudol, John E.	106 Broad St., Bloomfield	Essex	....
Toelgel, Alois	N. J. State Hosp., (Ancora) Hammonton	Camden	Psy
Valeece, Vito A.	114 E. Clements Bridge Rd., Runnemede	Camden	General
Wasserman, Harold	65 Park Pl., Irvington	Essex	....
Wegryn, Stanley P.	109 Springfield Rd., Elizabeth	Union	Resident
West, William A.	216 Avon Rd., Haddonfield	Camden	Resident
Westlin, William F., Jr.	129 Summit Ave., Summit	Union	Ped
White, Robert R., III	129 Summit Ave., Summit	Union	Urol
Williams, David M.	723 Watchung Ave., Plainfield	Union	Int Med
Williams, Eric S., Jr.	102 S. 14th St., Newark	Essex	....
Wilson, Edwin R.	715 Broadway, Paterson	Passaic	Orth Surg
Wirtshafter, Alan F.	1 Primrose La., Levittown	Burlington	General

Council on Public Relations

Following is a resume of items dealt with by the Council on Public Relations at its meeting on Wednesday, March 16, and submitteed for the information and action of the Board of Trustees:

Identifying Membership Card . . . recommendation: To facilitate the identification of members and Associate members of The Medical Society of New Jersey before the public and other members of the medical profession, the Council recommends that the Board authorize it to prepare an appropriate identification card, to be distributed annually to members and Associate members in good standing through the offices of secretaries of component county societies.*

The Council received and considered two items from the Board embodying the following recommendations:

(a) "That The Medical Society of New Jersey continue to publicize the seriousness of glaucoma as a blinding disease."

The Council pointed out that it has been doing this over the years, in conjunction with its publicizing the Eye Health Screening Program and by means of appropriate *Health Hints.*

(b) "That the type of program (to encourage tetanus toxoid immunization) and dissemination of information be left to the Council on Public Relations for whatever action they deem advisable."

The Council made initial plans for authorizing the recommendation.

Golden Merit Award . . . The Council unanimously approved the 24 candidates submitted by county medical societies to receive the Golden Merit Award this year.

Membership Decals . . . In conjunction with the plan for distribution of the decals, it was agreed that they will be made available in adequate supply to the secretaries of county societies and that a statement will also be supplied—to be given to each member with his decals—setting forth the regulation concerning their display and other pertinent information concerning their use.

"Political Medicine is Bad Medicine" . . . The Council approved for general distribution to all physician-members copies of the A.M.A. pamphlet, "Political Medicine is Bad Medicine."

It is the thought of the Council that members of the Woman's Auxiliary could assist county secretaries in delivering copies of the pamphlet in bulk to physicians for use in their offices and in encouraging the use of these pamphlets in physicians' offices.

*This was disapproved by our Board of Trustees at its March 20 session (1960).

Courses for Ophthalmologists

The Institute of Ophthalmology of the Americas announces graduate courses in Ophthalmology from September 12 through November 23, 1960.

Catalogues and additional information may be obtained from the Registrar, Institute of Ophthalmology, Eye and Ear Infirmary, 218 Second Avenue, New York 3, N. Y.

Neurologic Residency Approved

The Veterans Administration Hospital, East Orange, has received accreditation from the American Medical Association for a 3-year residency program in neurology. For further information, write to Dr. John A. O'Hale, Director, Professional Services, VA Hospital, East Orange. N. J.

County Society Reports • • •

Bergen

The annual meeting of the *Bergen County Medical Society* held May 10 at Bergen Pines Hospital, Paramus, was called to order by Donald B. Hull, M.D., president. Dr. Robert R. Grimes served as secretary *pro tem.* Dr. Grimes introduced the following Associate members elected April 12: Drs. Joseph J. LoFaro, Gene-Ann Polk, and Francis C. Symonds, Jr. Dr. Grimes read the names of Dr. A. L. Davidson and L. L. Perkel for Courtesy membership.

All five were elected to the grades of membership indicated.

Dr. Verdon made the second reading of the two By-Law amendments introduced at the last meeting and moved their adoption. After being seconded, the amendments were adopted.

Dr. Verdon called attention to the fact that nominations from the floor can be entertained but that the by-laws were inconsistent with respect to the time such nominations could be made. He recommended that Article V, section 2 be amended to provide nominations from the floor at the meeting at which the new class of delegates was elected, and offered an amendment to effect this change. This proposal will have its second reading at the June session.

Dr. Rowohlt exhibited clippings of releases published by the *Bergen Evening Record* during the week of April 26. These clippings were placed on the rostrum for the perusal of interested members after the meeting.

Dr. Olpp read a resolution from the Mercer County Medical Society expressing strong opposition to Assembly Bill No. 556 which would permit the Commissioner of Banking and Insurance to set physician fees in Medical-Surgical Plan contracts. He then moved that we endorse the Mercer County resolution. After considerable discussion, the motion was tabled. Thereafter Dr. Olpp presented the folowing resolution which was adopted.

Whereas, with the introduction of Assembly Bills No. 556, 612 and 60 in the New Jersey State Legislature, it becomes necessary to resist the invasion by legislative enactment of the freedom and rights of the members of the medical profession, be it

Resolved, that the Bergen County Medical Society go on record as opposing Assembly Bills No. 556, 612 and 60 and all similar legislation; and as supporting any official position or action of The Medical Society of New Jersey in opposition to these bills and any similar legislation which encroaches on the free practice of medicine by non-medical groups or individuals, and be it further

Resolved, that this resolution be forwarded to The Medical Society of New Jersey for presentation before the May 1960 meeting of the House of Delegates.

The treasurer, Dr. J. P. O'Connor reported that of 602 Active members, dues have been received from 581; that all 43 Associate members have paid their dues; and that all but 2 of the 34 Courtesy members' dues have been paid. All Blue Cross premiums have been paid.

Report of Nominating Committee: Dr. George Heller, Chairman, presented the following names for officers and member of the Judicial Committee which had been placed in nomination at the April Regular meeting: *President*—George Rowohlt; *First Vice-President*—Walter Wahrenberger; *Second Vice-President*—Samuel B. Reich; *Secretary*—Charles P. Campbell; *Treasurer*—John P. O'Connor; *Assistant Treasurer*—Alfred A. Alessi; *Judicial Committee*—Leo J. Fitzpatrick. Nominations were closed and the Secretary cast one ballot for these candidates. The nominees were declared elected.

Dr. Reich, Chairman of Program, presented Dr. F. Clyde Bowers, President of The Medical Society of New Jersey. Dr. Bowers suggested that the national problem on the care of the aged and aging is a problem only because politicians say that it is. Although temporarily stymied, a rash of plans for governmental medical care have been forthcoming from organized labor, the Democratic Party, and even the present administration. This will have to be faced in the campaign prior to the November election.

Dr. Bowers pointed out that New Jersey was among the first to promulgate a plan for reduced fees for the aged indigents which has been approved by the Commissioner and will become operative when 51 per cent of the physician population of each county has signed up as participants. The general average for New Jersey is only 48 per cent. Bergen County has the lowest record to date with only 37 per cent signed up. Dr. Bowers made a strong plea for members to execute and return the form for this purpose with no further delay. He reminded the members, in answering a question that it was *not* necessary for a member to be presently a participating physician of the Medical-Surgical Plan of New Jersey in order for him to agree to this new reduced fee plan.

Dr. Reich then introduced Mr. Richard I. Nevin, Executive Officer of The Medical Society of New Jersey. Mr. Nevin said that the present open hostility towards the practice of medicine in the country was simply a diversionary tactic on the part of those who embraced more and more socialism in government. The public was becoming increasingly aware of their problems because of increased taxes,

inflation, the decreasing purchasing power of the dollar, and the tremendous sums being committed for national defense and overseas aid. The governmental medical care program was therefore a red herring but had become a real problem to be faced. Mr. Nevin felt that the best efforts of the physicians were needed because the concept of the doctor as the benefactor of mankind was worth defending against all others who covet this distinction. He warned "Don't let your humanness overwhelm your humanity" and stated that physicians must stand together in defense of their prerogatives lest they all hang separately.

A spirited question and answer period followed with both speakers answering many pointed questions.

There being no further business to come before the meeting, it was adjourned at 10:45 p.m.

ROBERT R. GRIMES, M.D.

Reporter *pro tem*

Burlington

Deborah Sanitarium was host to the *Burlington County Medical Society* for its regular monthly meeting on April 14. The program, entitled "Planigraphy in Chest Diagnosis," was discussed and illustrated by Dr. George N. J. Sommer of Trenton, Chief of Pulmonary Surgery and Bronchoscopist to Deborah; Dr. Joseph M. Fruchter, Radiologist to the hospital; and Dr. Nathan Ralph, Medical Director. This well illustrated discussion clearly and vividly demonstrated the value of body section x-ray films in diagnosis of otherwise obscure shadows in the lung fields.

A business meeting was held following the presentation. Dr. John L. Ingham was unanimously elected an Associate member of the Society.

Deborah Hospital served a delicious late supper following the meeting and as usual the Medical Society is greatly in their debt.

LINDLEY B. REAGAN, M.D.

Reporter

Cumberland

A meeting of the *Cumberland County Medical Society* was held at Richards Farm, Rainbow Lake, on April 12, with Dr. Alfred O. Davies, President-elect, presiding. Annual election of officers was held. Those to assume their duties in June are: *President*—Alfred O. Davies, M.D., Millville; *Vice-President*—Harry A. Reinhart, M.D., Vineland; *Secretary*—Mary Bacon, M.D., Bridgeton; *Treasurer*—Earl C. Lyon, M.D., Bridgeton; *Reporter*—Leonard G. Scott, M.D., Bridgeton. Members of the Executive Committee (1 year)—Robert A. Levenson, M.D., Vineland, Ralph S. Phillips, M.D., Bridgeton; Edward J. Chmielewski, M.D., Millville. Delegates to The Medical Society of New Jersey—Nicholas Marchione, M.D., Vineland (1963); Philip H. Hover, M.D., Vineland (1963). Alternate Delegates—Samuel B. Pole, III, M.D., Bridgeton (1963); Charles Cunningham, M.D., Vineland (1963). Nominating Delegate—Carl N. Ware. M.D., Bridgeton; Alternate—Mary Bacon, M.D. Judicial Committee—Benjamin Berkowitz, M.D. Cumberland Nominating Committee (1 year)—M. David Baxter, M.D., Vineland; Jesse W. Carll, M.D., Bridgeton; William S. Fithian, M.D., Bridgeton.

Dr. Frank Aitken indicated representatives of the American Cancer Society who might be called on for the needs of the indigent.

The following resolution on the death of George N. Thomas, M.D., was adopted:

Whereas George N. Thomas, M.D., after a long career in the practice of medicine, has expired, and

Whereas Dr. Thomas graduated from Jefferson Medical College in 1923; was a member of the Cumberland County Medical Society since he moved to this county, and its president in 1946; a member of The Medical Society of New Jersey; a member of the staff of Newcomb Hospital, and has served faithfully as its president, chief of surgery, chief of obstetrics and gynecology and as chairman of many of the hospital committees; a fellow of the International College of Surgeons (1946) and

Whereas Dr. Thomas was a good citizen in the community where he lived and active in all things progressive and had served his community as police physician and borough medical officer.

Now Be It Resolved that the Cumberland County Medical Society recognizes its loss; spreads this resolution on its minutes and sends a copy to the widow and family and will have the same placed in THE JOURNAL of The Medical Society of New Jersey.

Vincent Giacalone, M.D., of Vineland, was made an Emeritus member by the Society.

The speaker Bernard Ronis, M.D., Professor of Otolaryngology, Temple University School of Medicine, spoke on "Hope for the Deaf." A color film augmented his lecture.

The meeting adjourned for dinner.

LEONARD G. SCOTT, M.D.

Reporter

Gloucester

The regular monthly meeting of the *Gloucester County Medical Society* was held on April 21 at the Homestead Coffee Shop in Woodbury.

The meeting was presided over by Dr. Dorothy M. Rogers, president. Dr. Thomas Flynn introduced the speaker of the evening, Dr. Kraeer Ferguson, Professor of Surgery at the Graduate School of the University of Pennsylvania. The scientific portion of the program as conducted by Dr. Ferguson consisted of a brief yet complete discussion of an outline of surgery of the ambulatory patient. The basic fundamental knowledge of treatment in the office with the types of lesions involved were outlined. This was followed by a discussion of tendinous injuries and their treatment, superficial lesions including aspiration of breast cysts and treatment of anal lesions. The discussion was well received by the entire audience to whom Dr. Ferguson's work and well-known textbook have been known for years.

The business portion of the meeting followed during which the minutes of the March meeting were approved; and Dr. George Booth, the treasurer, reported that all members have paid dues. A motion was made by Dr. Patterson, seconded and carried, that our delegates be instructed to express their opinion to the State Society regarding the necessity of continuing the Joint Committee on survey and accreditation of medical schools to the AMA. The constitution as revised was also approved. Proposed nominations for the coming State Medical meeting were discussed. It was agreed the delegates should go uninstructed to Atlantic City, but that the delegates vote *yes* to the question: "Should the present ratio on voting be maintained?" It was decided to purchase a Ditto Duplicator. Following this, the meeting adjourned and a well received luncheon was enjoyed by all those in attendance.

WILLIAM D. KEHLER, M.D.

Reporter

Hudson

With Dr. Charles A. Landshof presiding the regular meeting of the *Hudson County Medical Society* was held at Jersey City Medical Center on April 5.

Speaker of the evening was Mr. James R. Zotti, Assistant Manager, Physicians Relations Section of the Medical-Surgical Plan of New Jersey. Mr. Zotti's subject was "Recent changes in the Medical-Surgical Plan." Many doctors participated in a discussion from the floor.

A report from the Public Health Committee was given by Dr. Sigmund Braunstein, chairman. This dealt with a request from the State Department of Health for the cooperation of the members of the Society for effective control of venereal disease and tuberculosis.

Dr. Landshof asked for the cooperation of the membership in a publicity campaign against Bill A-556 which would give the State Banking Commissioner the right to fix fees in the Medical-Surgical Plan.

Following the business meeting, a collation was served.

ROY A. MORROW, M.D.

Reporter

Mercer

Dr. S. Gordon Castigliano, of the Oncological Hospital of Philadelphia, was the guest speaker at the Installation Meeting of the *Mercer County Component Medical Society,* held Wednesday evening, May 11. Subject of Dr. Castigliano's presentation was "Head and Neck Malignancy and the Physician."

The meeting was conducted under the chairmanship of Dr. John A. Kinczel, president. During the session, a motion was passed, concurring with the resolution unanimously adopted by the Middlesex County Medical Society, which opposes the "pilot" plan on a funded basis for medical eye care, made available to unions by means of a third organization. We approved the Mercer County Association of Medical Assistants' proposed constitution and by-laws, and adopted a resolution on the death of Dr. Samuel C. Jaspan, who died April 3.

Drs. Bohdan Faraoniw, Edmund A. Foster, William F. Haynes, Jr, Robert J. Keene, Tatjana Schummer, and Mario L. Zingarini were elected to Associate membership.

At the conclusion of his term of office, Dr. Kinczel introduced Dr. Peter J. Warter, who will serve the society as its president during the year 1960-61. Dr. Warter, in turn, introduced his fellow-officers: Dr. Walter R. Peterson, Vice-President; Dr. I. Frank Bird, Secretary-Reporter; and Dr. Robert J. Ryan, Treasurer.

R. N. CAGAN, M.D.

Reporter

Middlesex

Roosevelt Hospital was host to the *Middlesex County Medical Society* at its regular monthly meeting on April 20. Dr. John A. Smith, the president, presided. March meeting minutes were accepted as read.

It was announced that the next meeting will be held on May 25 and the June meeting on June 22.

The Nominating Committee, Dr. Gerard R. Gessner, Chairman, submitted the following panel of candidates for submission to the annual meeting in June: President—Dr. Stanley A. Gadek, Perth Amboy; Vice-President—Dr. Thomas F. McLaughlin, Metuchen; Secretary—Dr. Donald T. Akey, Metuchen; Treasurer—Dr. Reuben Levinson, Perth Amboy; Reporter—Dr. Thomas I. Steinberg, Metuchen. Board of Trustees—Dr. John A. Smith, Chairman; Dr. Charles H. Calvin, Dr. Malcolm M. Dunham, Dr. Charles Gandek, Dr. George T. Henderson, Dr. George J. Kohut, Dr. Joseph F. Sandella, Dr. A. Marshall Smith, Sr., Dr. B. F. Slobodien. Judicial Medical Ethics Committee—Dr. B. F. Slobodien, Chairman, Dr. R. E. Siegel, Dr. E. J. Tyrrell (one year); Dr. S. David Miller, Dr. W. Edgar Sherman (two years). Delegates and Alternates to the House of Delegates, The Medical Society of New Jersey (three years): Delegates—Dr. Donald T. Akey, Dr. R. G. Matflerd, Dr. John H. Rowland, Dr. Jack E. Shangold, Dr. Thomas F. McLaughlin, Dr. Eugene J. Tyrrell, Dr. John S. Van Mater; Alternates—Dr. William Toth, Dr. Martha F. Leonard, Dr. S. David Miller, Dr. Albert A. Schwartz, Dr. William Rubin, Dr. George J. Schiebel, Dr. Joseph C. Vargyas. Nominating Delegate—Dr. Charles H. Calvin; Alternate—Dr. Gerard R. Gessner.

The Society voted to purchase advertisement space in the "yellow pages" of the Middlesex County telephone directory for emergency call numbers at a cost of $275 per year.

The Society was doubly honored to have Dr. Clyde Bowers, President of The Medical Society of New Jersey speak on "Senior Citizen Insurance Contracts." He recommended accepting challenge of "over 65" Blue Shield plan. He advocated this as a positive proof to the public of what we are doing —caring for older low-income families at reduced rates. He is fearful that other forces in the community will force some other "Forand" type legislation onto us if we do not take positive steps ourselves.

Mr. Richard I. Nevin, Executive Officer of The Medical Society of New Jersey, gave an excellent talk on our place in American society and how we must fight against those trying to destroy the American system from within just as we would fight any disease.

On recommendation of the Judicial-Medical Ethics Committee, the application of Dr. Man Wah Cheung, for Regular membership from Associate membership was recommended for presentation to the Credentials Committee of The Medical Society of New Jersey for election.

The meeting was adjourned and collation served.

THOMAS I. STEINBERG, M.D.

Reporter

Monmouth

The April meeting of the *Monmouth County Medical Society* was called to order at 9 p.m. on April 27, by Dr. Lester Barnett at Monmouth Medical Center, Long Branch. Elected as a delegate to the State Medical Society was Dr. Anthony De Spirito and the alternate delegate elected was Dr. Harold Gabel. Elected to the Executive Committee was Dr. Urey Parkhill.

Dr. Daniel Featherston, member of the State Society's special study committee on professional liability insurance, reported on preliminary plans for group policies for professional liability insurance.

Dr. Charles Zukaukas, chairman of the Indoctrination Committee, presented the new recommendations of the committee for the prerequisites to be fulfilled by associate members before election to active membership. These recommendations included the extension of the associate membership from one to two years and compulsory attendance at 70 per cent of the meetings during the period of associate membership, and compulsory availability for the emergency medical service during this period regardless of the specialty the associate member practices.

These recommendations were generally approved by the membership, and were submitted in the form of an amendment to the by-laws. These will be presented at the May meeting for final passage and incorporation into the by-laws.

Dr. Anthony L. Rifici, chairman of the Emergency Medical Service Committee, reported on the work of the committee. A survey was taken of the membership by mail inquiring of their willingness to participate in the emergency medical plan. One hundred fifty members replied and 80 responded favorably. This number plus the 15 associate members will form the nucleus for the emergency medical service.

A motion was made by Dr. John Clark that all members of the medical society under 50 years of age have compulsory participation in the emergency medical service. This motion was defeated by a close vote, the opposition expressing the sentiment that it would be extremely difficult to force recalcitrant members to serve while those volunteering could be depended upon more readily. Dr. Harold Bowne, Chairman of the Public Relations Committee, presented very illuminating reports supplied by two of the hospitals. He noted that there are 163 physicians at Monmouth Medical Center, Long Branch, and 136 physicians at Fitkin Memorial Hospital in Neptune who give a total of 54,794 free hours of work within the hospital per year, representing a total volume of free services of over $1,000,000. Dr. Bowne noted that the laity considered availability and personality more important attributes in their evaluation of a physician than ability, illustrating (1) the need for the emergency medical service and arrangements

for coverage when a physician knows he is going to be away and (2) for compassion and sympathy when dealing with the patient.

Dr. Harold Gabel, Program Chairman, announced that the next meeting, which will be held at Fitkin Memorial Hospital, on Wednesday evening, May 27, will have as its speaker, Dr. Herbert Kupperman of New York University School of Medicine who will speak on "The Current Use of New Hormones."

LEONARD S. DANZIG, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on April 19 at 8:45 P.M. at the Alexander Hamilton Hotel in cosponsorship with the Passaic County Bar Association.

Mr. Harry C. Peterson, Esq., president of the Bar Association, welcomed those attending and turned the meeting over to Dr. Julian Cohen, president of the Passaic County Medical Society. Dr. Cohen thanked the Bar Association for inviting the officers of the Society and the panel members to a dinner prior to the meeting.

Dr. Cohen presided over the business session of the meeting. The following Delegates were unanimously elected to fill vacancies in the list of Delegates to the Annual Meeting: Samuel T. Bernson, M.D., Earl L. Warren, M.D., Edward A. Wolfson, M.D. and Joseph M. Keating, M.D.

Dr. Cohen read a resolution which was adopted for presentation to the 1960 House of Delegates of The Medical Society of New Jersey. The resolution urged that licensed M.D.s be eligible to serve as Health Officers without additional certificates.

The meeting was then turned over to the moderator, Mr. Samuel Doan, attorney, of Paterson. Mr. Doan introduced the members of the Medical Society on the Panel: Drs. Roy Schubert, Attending Orthopedist, Paterson General Hospital; David Roth, Associate in Medicine, Barnert Memorial Hospital; and Joseph Zigarelli, Associate Attending Psychiatrist, Paterson General Hospital. He then introduced the members of the Bar Association: Judge Hugh Spernow and Carl Gelman, Esq., of Paterson.

The subject of the Panel Discussion was the Inter-Professional Code of conduct adopted by the American and the New Jersey State Bar Associations, and by The Medical Society of New Jersey. The discussion was exceptionally interesting and informative and was enthusiastically received by the audience. A collation was served following the adjournment of the meeting with the Passaic County Bar Association as hosts.

IRVING CHRISMAN, M.D.

Reporter

Salem

The annual meeting and shad dinner of the *Salem County Medical Society* was held on May 7 at the du Pont Penns Grove Country Club. Dr. Ford C. Spangler of Salem succeeded Dr. George A. Nitshe, Jr. of Monroeville who had guided the group over the past year.

Dr. William L. Sprout, Salem, replaces Dr. Spangler as vice-president. Other officers are: Dr. Donald A. McLean, Salem, Treasurer; Dr. George F. Reichwein, Pennsville, Secretary; and Dr. Frank W. Winters, Mannington, Reporter.

Among the visitors on hand were Dr. F. Clyde Bowers of Mendham, President of The Medical Society of New Jersey, and Dr. Jesse McCall, Newton, President-elect of the state organization. Also, Dr. Carl N. Ware, Shiloh, Trustee of the state society representing the Cumberland-Salem county groups. They were accompanied by their wives.

Welcomed to their first annual meeting of the county society were Dr. and Mrs. John T. Dooley of Salem.

Guest speaker at the meeting was Ray Howe, Chairman of the Department of Education at the Museum of Natural Sciences, Philadelphia. His very informative talk entitled "Alaska—Land of Conquest" was illustrated with colored slides and depicted the great differences between the large cities of Alaska and the icy wastes. Of particular interest was the similarity of many portions of the territory to areas in the United States. Mr. and Mrs. Howe spent several months living among the Eskimos, hunting and fishing with them. The descriptive narration of the home life and the customs of the natives was most enlightening.

G. F. REICHWEIN, M.D.

Reporter

Woman's Auxiliary • • •

Mrs. Ralph K. Bush: Auxiliary President

The new Auxiliary president, Margery Ashby Bush, comes from the Great Plains of Kansas. She was graduated from the Westport High School in Kansas City. She then attended the University of Kansas at Lawrence, and finished teacher training at Washington University in St. Louis. After teaching in the public schools of her native state, she received an appointment to teach in South Jersey.

Mrs. Bush has been active in many civic affairs—the Auxiliary to the Cooper Hospital in Camden, for instance; the First Presbyterian Church in Merchantville, and the Burlington Country Club. She was in the Woman's Motor Corps during World War II and took active part in bond drives. Mrs. Bush served the Woman's Auxiliary to the Camden County Medical Society in almost every capacity. She was president of that Auxiliary in 1954. She has also been active in the Woman's Auxiliary to The Medical Society of New Jersey, and worked for six years on our State Executive Board.

Mrs. Bush's interests are widespread. She has shown herself an effective organizer. She is a perceptive bird watcher, a golf player of more than average skill, a sensitive music appreciator, and a talented bridge player.



She has also devoted special attention to Auxiliary work in legislation, recruitment for health careers, parliamentary procedure and public relations.

Obituaries • • •

DR. SAMUEL C. JASPAN

On April 3, Dr. Samuel C. Jaspan of Trenton, died at his home. Born in 1889, Dr. Jaspan earned his M.D. degree at the University of Pennsylvania in 1912. He was active in Masonic and county medical society affairs. A "family doctor" in the traditional sense, Dr. Jaspan was proud to be identified as a general practitioner and served the people of Mercer County day and night for almost half a century. Dr. Jaspan was 71 years old at the time of his death.

DR. NATHANIEL J. SHAPIRO

On April 14, 1960, at the age of 77, Dr. Nathaniel J. Shapiro of Union City, died of an acute coronary attack.

An eye, ear, and nose specialist for many years, he served on the staff of the New York Post-Graduate Medical School of Columbia University, as an instructor. He was also on the staff of the North Hudson Hospital in Weehawken, N. J. He was a School Physician, City Physician, and Health Officer in Union City.

Dr. Shapiro was born in Russia in 1883. He graduated from the New York Eclectic Medical College in 1907. Three years ago he was given the Golden Merit Award by The Medical Society of New Jersey. He was active in many civic and charitable institutions.

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Current Medical References. Edited by P. J. Sanazaro, M.D. Los Altos, California, 1959. Lange Medical Publications. Pp. 535. Heavy paper covers. ($3.50)

This volume must be unique in medical literature. It consists of nothing but citations, grouped under such headings as "obstruction of the aorta" or "fluid balance." A good index leads the reader to the appropriate section. There is no attempt to cover surgery or psychiatry but there are many references in neurology. Attached to every citation is an indication of how many references and footnotes the article has. Apparently only the nationwide medical journals are used as sources as there are very few references to state journals. In all there must be 10,000 citations here. The book provides a real and unusual service to readers and can become the springboard for many fine studies. Someone ought to write a similar volume for surgery.

ULYSSES FRANK, M.D.

Atlas of Roentgenographic Positions. Written and Compiled by Vina Merrill. St. Louis, 1959. Mosby. Pp. 681, with illustrations. Ed. 2. 2 Vol. Cloth. ($32.50)

Mr. Merrill has provided a ready reference source for roentgenographic positions in his Atlas. It has been useful in standardization of radiographic examinations.

The second edition follows the same excellent plan of description, drawings, illustrations and radiographs that characterized the first edition. The Atlas describes the material so well that anyone, whether a student of radiology or the experienced radiologist and technician, will find here an excellent guide for the reproduction of any position for a radiographic examination. The student has a useful, logical reference from which to learn his art. The trained radiologist and technician have an authoritative source to refresh themselves of little used technics and positions.

The Atlas has wisely included an expansion of the bibliography and corrections in the terminology that has pinpointed descriptions more concisely and removes some misnomers and corrected some concepts through acceptable terminology.

This Atlas can be recommended to every laboratory of radiology as a ready, usable and accurate source for gaining the correct position for the most valuable radiographs.

JOHN J. THOMPSON, M.D.

Legal Environment of Medical Science. National Society for Medical Research, 920 South Michigan Blvd., Chicago, 1959. Pp. 114. Paper.

In May 1959 the National Society for Medical Research sponsored a colloquium at the University of Chicago on three medicolegal questions; the use of cadavers and transplants and the medicolegal aspects of autopsies; the legal problems of animal experimentation; and the legal aspects of clinical research on human beings. This booklet is a transcription of the session including running remarks of commentators and participants. It discusses such problems as what is "knowing consent" to the use of a new drug—when is this an experiment, when is it treatment? There has never been any brochure quite like this and it opens a whole new field of medical literature and scientific inquiry.

VICTOR HUBERMAN, M.D.

Smoking and Health. By Alton Ochsner, M.D., New York 1959. Julian Messner, Pp. 108. ($3.00)

Here is an angry book. Dr. Ochsner, the distinguished surgeon, cites evidence that indicts smoking as a factor in peripheral vascular disease, coronary disease, peptic ulcer and cancer of the respiratory tract. The book opens with the statement: "Cigarettes cause cancer." The author points out that the cigaret industry grosses about 6 billion dollars a year; spends less than a half million on research but many many millions on advertising to persuade people to smoke. Lung cancer, prior to World War I, was an exquisitely rare disease, and now, of course, it is frightfully common. "Smoking" says Ochsner, "has given the world a new disease." Some 95 per cent of lung cancer deaths, he finds, are "traceable to smoking."

In 1952, filter-tip cigarets accounted for 1½ per cent of sales. Today filter-tips account for 55 per cent. Ochsner finds, however (as did the Surgeon General a few months ago) that filter-tips don't substantially reduce the risk. And king-sized cigarets, he points out, lead to king-sized cancers because there are more arsenic and other cancerogens in big cigarets than in little ones.

The cigaret industry would like to believe that lung cancer is no more common than ever, but argues that it is merely better recognized. Ochsner shows that in central Europe where autopsies are practically routine, figures show a significant increase in lung cancers. Nor can "smog" be blamed

since the rate is higher in smog-free (but cigaret-obsessed) Denmark than in foggy Britain. Sunny New Orleans has more lung cancer than Pittsburgh.

The author piles up evidence relating smoking to peripheral vascular, gastric and coronary disease. And—though this may be hitting below the belt—he writes that "decreased sexual activity of men in their forties can often be traced to excessive smoking."

While some readers will be repelled by Dr. Ochsner's intransigeance and dogmatism, there is no doubt that this is serious business; and that the occasion calls for the telling of blunt truths rather than a display of good sportsmanship. Of course, he who does not want to believe this, can find many loop holes in the author's logic. Only a direct experiment on human beings would prove the thesis and no one proposes that. But from the evidence already adduced it would seem that fear of smoking is a way of saving lives.

HENRY A. DAVIDSON, M.D.

Metabolic Care of the Surgical Patient. By Francis D. Moore, M.D. Philadelphia, 1959. Saunders. Pp. 1011. ($20.00)

This voluminous work brings together an area of knowledge that has grown from many sources in the past fifteen years. The book discusses the supportive measures, other than operation, based on an understanding of the patient's bodily processes in recovery. This distinguished author and lecturer has amassed in one volume a guide book for metabolic care in surgery.

Many New Jersey surgeons have had the opportunity to hear the author lecture or to take one of his courses during the last few years. In this book they have a well-organized work, divided into six parts, each having its own discussion, notes from the literature, clinical procedure and case records. There is an extensive bibliography.

Normal body composition, physiology, metabolism and surgical endocrinology are reviewed. The chapters on blood volume and hemorrhage as well as those on body fluids and electrolytes are monographs in themselves. The case records document individual surgical stories that bring out a variety of points. The effects of cachexia and malignancy as they relate to metabolism are described. Many graphs illustrate the printed material. Treatment in a practical manner is painstakingly outlined at the end of each chapter. The diseases of the gastrointestinal tract are described in greatest detail, as are parenchymatous diseases of the liver, kidneys, lungs, heart and endocrine glands as they relate to surgical care. The case studies outlined in this section are educational gems and make facile reading. Fractures, wounds and burns, both in wartime and civilian life, present a multitude of special metabolic problems. These topic are well covered, and a final chapter is a timely contribution to atomic injury.

This excellent book, in spite of its thousand pages, is not repetitious or prolix. The author presents a scientific, but practical method of treating the whole patient, maintaining that surgical management, surgical technic and metabolic care are inseparable.

While, as the author states, it is not necessary or even desirable to be an electrolyte expert or an endocrine specialist in order to take care of the average post-operative case, it is important that every surgeon be cognizant of the need for knowledge along biochemical lines. He must know when to call for help when needed and before so-called irreversible changes take place. Therefore, every resident, research man and surgeon would profit by reading and preferably owning this fine reference work.

GEORGE F. HEWSON, M.D.

Some Observations on Control in Psychiatric Research. Group for the Advancement of Psychiatry. GAP, 104 East 25, NYC. New York 1959. Paper. Pp. 87. ($1.00)

Psychiatry does not have as strong a research tradition as do the other branches of medicine. In this thought-packed brochure, the GAP Committee on Research, under the chairmanship of Dr. David A. Hamburg, analyzes the idiomatic problems of psychiatric research. The role of the investigator and setting are, perhaps more significant in psychiatry than in other areas of medical research. Also discussed is the emotional involvement of the investigator, his need for finding answers, the problem of supervision, and the peculiar difficulties with setting up controls. This is a valuable dollar's worth for any research-minded worker in the behavior sciences.

HERBERT BOEHM, M.D.

Respiratory Physiology and its Clinical Application. By John H. Knowles, M.D. Harvard, 1959. University Press, Cambridge, Mass. Pp. 256. ($5.25)

Most of the 426 references at the end of this book have been published during the past decade. During this period, thanks to a few dedicated men, working in respiratory function laboratories, equipment has been greatly simplified, cost reduced and the procedures made so practical that more and more hospitals are installing these laboratories alone or together with a cardio-dynamic laboratory. This book will serve as an authoritative source of information and guide to those working in the laboratory as well as to the clinicians who will depend more and more on the interpretation of pulmonary function studies to confirm their clinical impressions.

Dr. Knowles discusses normal respiratory physiology and then describes the most practical tests which apply to the various phases of respiratory

function. A few tables are given with the accepted normal figures and then normal variations, which will serve as a guide. The material is clear and concise but the inexperienced reader will require supplemental reading and practical guidance in established laboratories.

The author also deals with the clinical application of pulmonary function studies to chronic pulmonary conditions as reflected by their pathologic physiology. Clinicians, who are on familiar ground, will appreciate these studies to supplement and corroborate their clinical impressions. It will also help convince them, that, in many of their patients with chronic pulmonary disease, a more accurate measure of respiratory function is available.

Pulmonary function studies will be of increasing importance, particularly in disability evaluation where a practical yardstick for accurate judgment is necessary. Clinicians, who are responsible for patients exposed to industrial hazards, who require surgery or recovered from accidents will find them increasingly necessary. The author's purpose in writing this text is to have it serve as a guide to the clinician. This mission is well fulfilled. For the student and beginner, this reviewer believes, more visual aids and diagrams would be helpful.

HENRY A. BRODKIN, M.D.

Christopher's Minor Surgery. Edited by Alton Ochsner, M.D. and Michael E. DeBakey, M.D. Philadelphia, 1959. Saunders. Ed. 8. Pp. 539. Illustrated. ($10.50)

All surgical conditions that can be handled in out-patient departments or doctor's office are considered here in some detail. Anesthesia and resuscitation, tumors of the skin and neck, infections, deformities and anomalies, diseases of the two ends of the alimentary tract, peripheral vascular diseases, and diseases of the nervous system—all are treated rather extensively. A chapter is devoted to the training of the surgical resident—which incidentally deals considerably with the problem of medical education as a whole. The chapters on genito-urinary conditions and on otology and layrngology, however, are quite brief, although complete. Three new chapters have been added to this eighth edition: (1) injuries to the hand, (2) diseases of the breast, and (3) physical medicine. The volume itself has been improved, being printed in larger type on a white background, giving a more legible book than the previous (1955) edition. In general then this is a standard text concerning things surgical in the ambulatory patient, containing a wealth of material. It is valuable to the general surgeon and particularly to the busy general practitioner as a reference book; and is also useful to the student as a text for study.

ALFRED D. YOUNG, M.D.

Fracture Surgery. By Henry Milch, M.D. and Robert Austin Milch, M.D. New York, 1959. Harper. Pp. 470. ($17.50)

Subtitled "A Textbook of Common Fractures," this is prepared to bridge the gap between small handbook and the more expensive treatise. It is particularly planned for the medical student and the surgical house officer.

Style and content are good, although use of the term "axial misalignments" is questionable. The sections on fractures about the elbow, epiphyseal injuries, fractures of the pelvic girdle and the vertebral column are excellent. The portion on regional anesthesia is concise and easily useable. This reviewer believes that the following sections could have been omitted: Care of soft tissue injuries, the more general sections on patient care, the elective treatment of some of the complications of fractures as, for instance, the resection-angulation operation in transcervical fracture of the femoral neck. These are beyond the avowed scope of the volume.

The general appearance of the book would be improved by omission of many of the x-ray reproductions, some of which are too large. The addition of simple schematic line sketches to demonstrate specific points would be an aid to clarity. Discussion of the indications for and technics of intramedullary fixation of fractures merits more space. The value of this volume to the medical student or house officer is questionable.

PETER J. GUTHORN, M.D.

First Hahnemann Symposium on Hypertensive Disease. Edited by John H. Moyer, M.D. Philadelphia, 1959. Saunders. Pp. 790. ($14.00)

This volume contains the entire proceedings of a symposium held in December, 1958, at the Hahnemann Medical College. There were panels on pathology, pharmacology, diuretics, surgery and therapy. Each panel session included one or more lectures and a moderated panel discussion.

This book would be difficult to use as a reference because panel discussions should be read straight through. On the other hand it is too bulky for thorough reading. All of the contents are covered by the current perodical literature. For these reasons the book is not recommended to the practicing physician.

The material contained in it is good. It might be more effectively useful were it broken up into smaller monographs and published in paperback editions. The practicing physician could then select that material in which he is interested and discard it when it becomes out of date.

DAVID BIBER, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

JUNE, 1960 • VOL. XXXII, No. 6

MANAGEMENT OF PREGNANCY COMPLICATED BY TUBERCULOSIS

The general practitioner should be alert to the possibility that tuberculosis may be present in a pregnant patient. Good results for both mother and child may be anticipated if there is careful prenatal and postnatal care and adequate treatment of the tuberculosis whenever it is active.

Current therapy for tuberculosis has led to treatment of fewer patients in tuberculosis hospitals and more as "outpatients" or on "home care." Thus, the management of the tuberculous patient, which previously was almost exclusively the domain of the phthisiologist, has now in part become the responsibility of the general practitioner.

The magnitude of the prob'em of pregnancy and tuberculosis is attested by the following statistics. Although tuberculosis has declined as a cause of death, one case is reported every six minutes. Tuberculosis is the leading cause of death from infectious diseases. Furthermore, of the approximately four million births a year in the United States, at least 40,000 occur in women with tuberculosis. The general practitioner should take an active part in the management of the pregnant patient with tuberculosis, just as he does in the patient with diabetes or heart disease.

INCIDENCE

The reported incidence of tubercu'osis complicating pregnancy depends in large part on the efforts made to diagnose it. At The New York Lying-In Hospital from 1933 to 1945, incidence ranged from 0.4 to 0.7 per cent. With the establishment of routine chest x-rays of all antepartum patients in June, 1945, the incidence rose to 1.5 to 2.0 per cent. Objection has recently been raised to the carrying out of routine diagnostic chest x-rays. The question may be asked: Are the dangers of omitting a chest x-ray in this woman greater than the risks of taking it? If the patient gives a positive reaction to tuberculin, the answer is yes. However, until the tuberculin test becomes routine for all antepartum patients in each pregnancy, routine chest x-rays with proper precautions should be performed.

GEORGE SCHAEFER, M.D., GP, *October, 1959.*

DIAGNOSIS OF TUBERCULOSIS

The degree to which the general practitioner considers tuberculosis as a possible cause of symptoms largely determines how quickly the disease is diagnosed. Since pulmonary tuberculosis is minimal in its early stages, progression and advanced disease may be avoided by early, adequate treatment. Not infrequently the pregnant patient complains of tiredness, fatigue, vague chest pains —symptoms that may occur in pregnancy but which are also present in tuberculosis. The tendency to ascribe these symptoms to the pregnancy without further investigation may be disastrous to the patient.

MEDICAL TREATMENT OF PULMONARY TUBERCULOSIS

The practitioner may be called upon to treat two types of pregnant patients with tuberculosis. The first is the patient known to have tuberculosis before the onset of pregnancy. The second is the patient in whom tuberculosis is first discovered during pregnancy. In either type the disease may be active or inactive. The patient known to have had tuberculosis before conception—tuberculosis that is inactive during gesta-

tion—does not require additional medical treatment. The patient known to have active disease at conception is continued on the same course of therapy as if she were not pregnant. This includes modified bed rest, either at home or in the hospital, and antimicrobial drugs. Our present preference is for isoniazid plus either streptomycin or PAS. Antimicrobial therapy is continued throughout the entire pregnancy and for at least six months postpartum.

The majority of patients whose tuberculosis is first discovered during pregnancy will be found to have inactive disease. These patients are managed in the same manner as those known to have inactive tuberculosis before the onset of pregnancy.

Active tuberculosis will be discovered in some patients during pregnancy. We advise that these patients be hospitalized. If the disease is minimal, isoniazid and streptomycin or PAS may be employed. Some advise isoniazid alone in this type of case.

The duration of hospitalization depends on several factors including response to chemotherapy and conversion of the sputum as well as on clinical and radiographic evidence of improvement. Other factors such as conditions at home, the presence of small children and the education of the patient in TB control, may determine whether to continue hospitalization until after delivery. Bed rest is no longer considered adequate therapy for tuberculosis. Furthermore, modified rather than complete bed rest is now advocated, and this is combined with specific drug therapy.

Antimicrobial drugs are used in all patients with active tuberculosis. The regimens and doses have been fairly well established. Treatment should be long-term and continuous, and to insure this the family physician must play an active role.

OBSTETRIC MANAGEMENT

In addition to medical treatment for the tuberculosis, the patient should have daily periods of rest. The diet should be supplemented with iron preparations and vitamins.

If the pregnancy and labor are to cause any progression of pulmonary tuberculosis, usually such changes will occur within three months of delivery. The results for our pregnant patients with tuberculosis compare favorably with a similar nonpregnant group of patients with tuberculosis.

Infants born of tuberculous mothers are normal in every respect. BCG vaccination is advised within the first 48 hours after birth for all these infants. Since BCG vaccination does not afford protection for six to eight weeks, the physician must be certain that no individual with infectious tuberculosis is at home when the infant is discharged from the hospital.

Following delivery the patient with inactive tuberculosis is ambulated slowly and kept in the hospital for approximately ten days. Women with active tuberculosis are transferred to a medical ward or to a tuberculosis hospital for further therapy. We do not permit tuberculous patients to breast feed their infants. Exacerbations of pulmonary tuberculosis may occur, because tuberculous mothers undertake household duties and the total care of the infant too quickly after returning home. Before assuming full activity, a sputum or gastric analysis should be repeated and an examination of the postpartum chest x-ray should reveal no evidence of activity.

Clinical observation and statistical analyses have convinced us that therapeutic abortion does not improve the prognosis of the pregnant patient who has tuberculosis.

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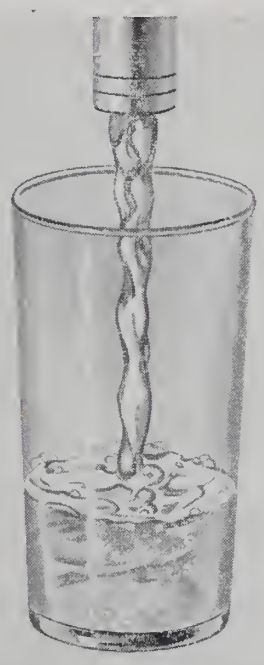
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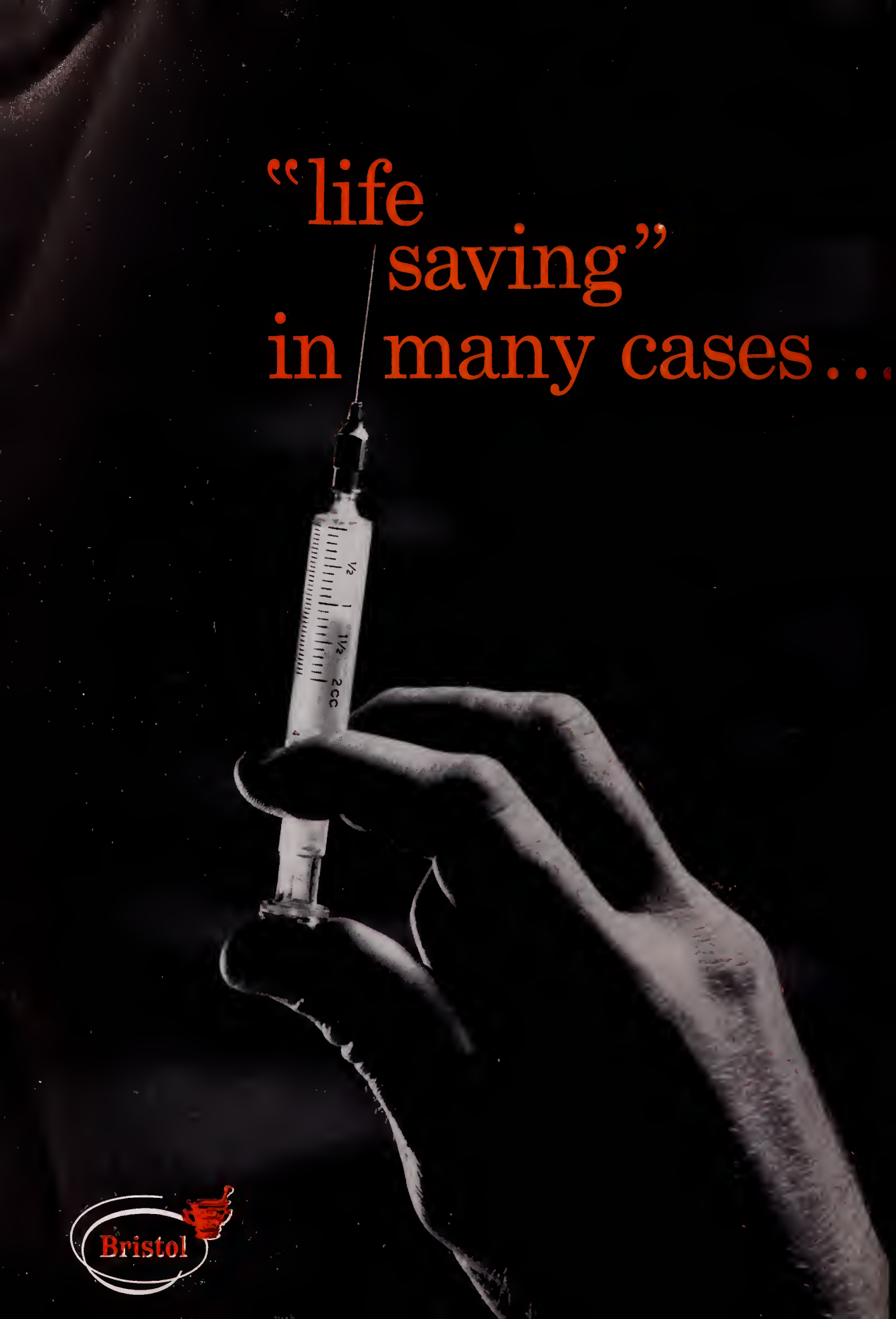
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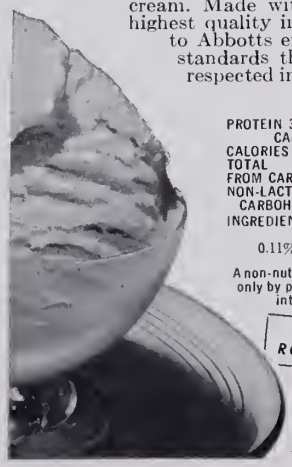
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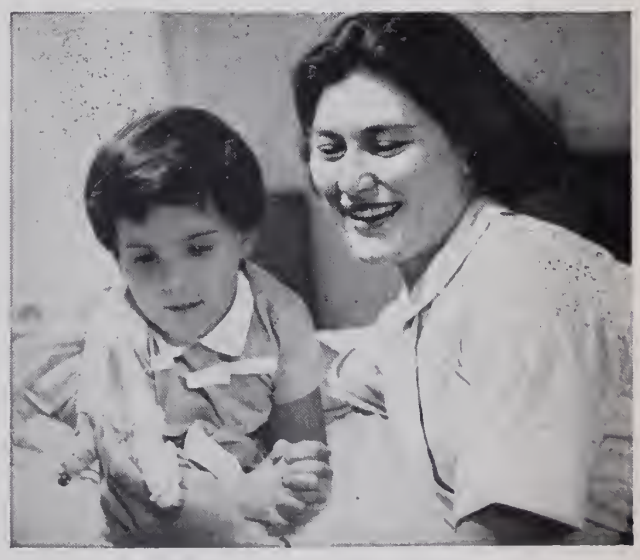
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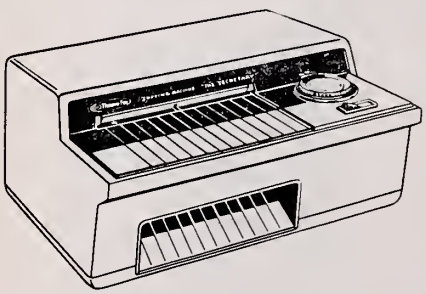
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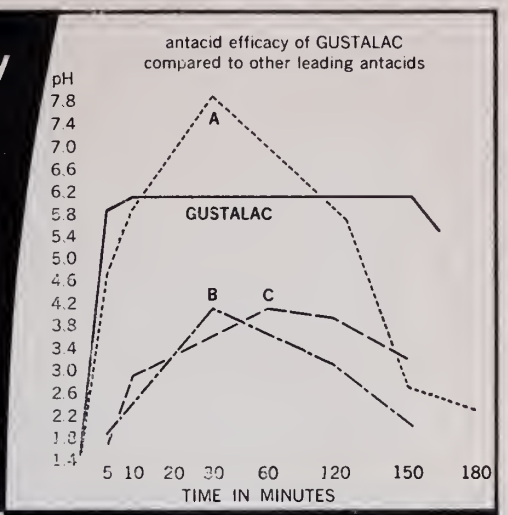
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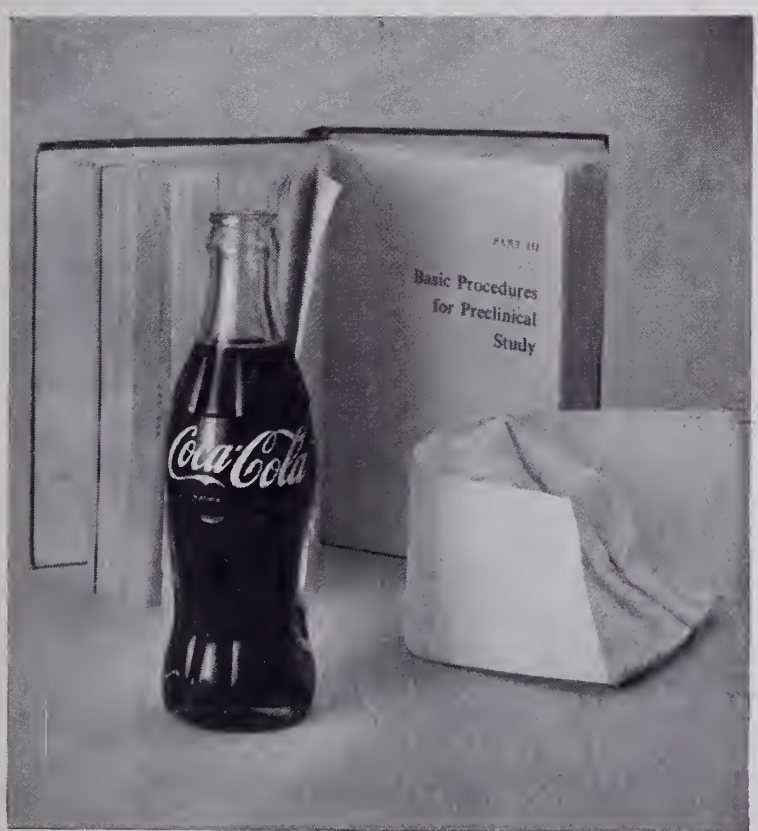
1. Kirstner, J. B.: J.A.M.A. 166:1727, 1958.

Samples and literature on request

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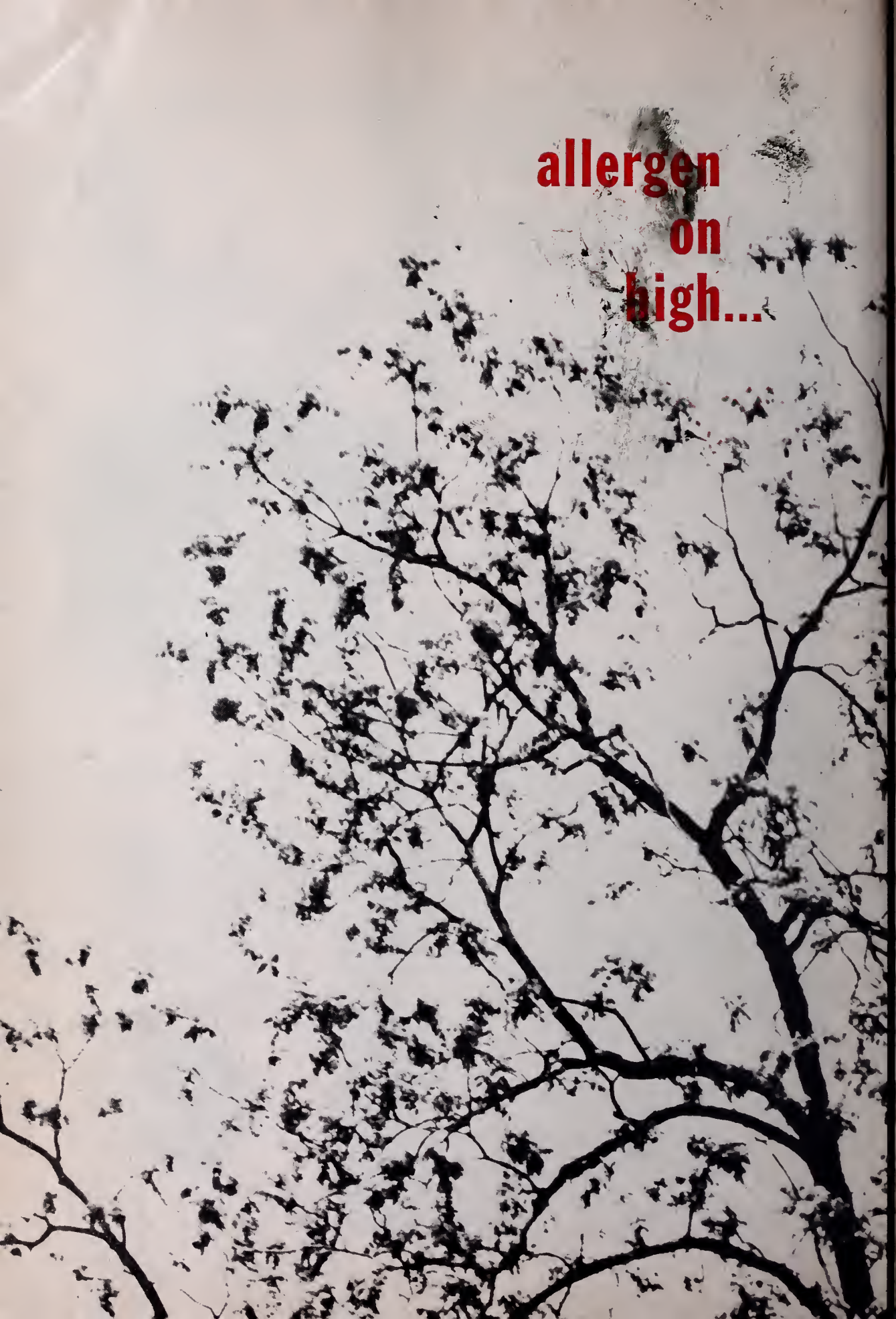
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